CONTINUING CARE: INTERNATIONAL PROTOTYPES FOR AMERICA'S AGED

HEARING

BEFORE THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

FIRST SESSION

JULY 15, 1985, NEW YORK, NY

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CONTINUING CARE: INTERNATIONAL PROTOTYPES FOR AMERICA'S AGED

MONDAY, JULY 15, 1985

House of Representatives,
Select Committee on Aging,
New York, NY.

The committee met, pursuant to notice, at 10:30 a.m., at the New York Hilton Hotel, Rockefeller Center, Hon. Claude Pepper (acting chairman of the committee) presiding.

Members present: Representatives Pepper, Biaggi, Manton, Siljander, and Bentley.

Staff present: Fernando Torres-Gil, staff director; Nancy Smith, professional staff member; and John Vihstadt, minority counsel; of the Select Committee on Aging. Melanie Modlin, deputy staff director, Subcommittee on Health and Long-Term Care; and Robert Blancato, staff director, Subcommittee on Human Services.

OPENING STATEMENT OF CHAIRMAN CLAUDE PEPPER

Mr. **Pepper**. The committee will come to order please. I am Representative Claude Pepper, of Florida, a member of the House Select Committee on Aging, and for a number of years chairman of that distinguished committee. The distinguished present chairman who succeeded me, the Honorable Ed Roybal has asked me to open this session this morning. However, as I have to leave, I will be succeeded by my distinguished colleague who is next to me, one of the high-ranking Democrats on the House Select Committee on Aging, one of the great champions of the elderly and America and a beloved friend of mine, the Honorable Mario Biaggi.

Mr. Roybal, who has been making a great record as chairman of the House Select Committee on Aging, was very anxious to be here today. He and his staff, particularly Miss Nancy Smith, and his distinguished staff director, Mr. Fernando Torres-Gil, have worked very hard—Mr. Torres-Gil is here on my right—in putting this hearing together. We wanted to have an opportunity to give the representatives of the elderly from sister nations an idea of what we were doing in America. We were particularly anxious to learn in more detail what they were doing in their respective countries, because we in our country here are very much aware of the necessity of our doing more in the area of continuing care than we are doing at the present time.

Mr. Roybal would be here today, but he was called upon to make a very important contribution in his home State of California today, and therefore, was unable to be with us. He has sent a very excellent and able statement and, without objection, I will ask that his statement be included fully in this record.

[The prepared statement of Chairman Edward R. Roybal follows:]

PREPARED STATEMENT OF CHAIRMAN EDWARD R. ROYBAL

Good morning. Today's hearing is a unique opportunity for members of the international congress of gerontology to share their experience in long-term care with a member nation, the United States. The committee is holding this hearing to learn how the experience of older Americans compares to that of elderly in other countries in their access to long-term care and their protection against related financial loss. We also wish to learn about specific cross-national models for providing and financing these services that can be used on behalf of America's aged as well.

Developed countries across the globe share a common challenge of increasing numbers of elderly citizens with increasing chronic care needs. While other countries have responded with innovative long-term care programs, older Americans remain largely unprotected. It is indeed humbling to realize that the United States—a world leader in defense technology and human rights—has money enough to protect its people from foreign enemies but does not commit resources to defend them against inappropriate and costly nursing home care.

The committee has had a long-standing interest in international health and a long-standing respect for the health care systems of other nations. This led in May 1984, to a hearing and chairman's report on international health issues affecting the aged. It is also reflected in the committee's continued support on the world assembly on aging's "international plan of action on aging", and of America's role in developing this world plan. Clearly, there is much that our countries can learn and share with one another as we address the needs of a growing population of world elderly.

In this spirit, the committee again approaches the international community on the critical issue of long-term care. We look forward to the testimony of our distinguished witnesses and appreciate their presence here today.

Mr. **PEPPER**. In addition to that, we all know that the U.N. Secretary General has been the very honored and able champion of the cause of the elderly and that he has done a great deal through the United Nations to advance the cause of the elderly throughout the world, especially that larger part of the world that is served by the United Nations organization.

He also is required to be overseas at this time, so he could not be with us this morning, but he has sent a letter, which I, without objection, will be incorporating in the record; and accompanying his statement is a resolution of the General Assembly of the United Nations on the causes and principles of the elderly. Without objection it also will be received in the record.

[The material submitted by Mr. Pepper follows:]

UNITED NATIONS—NATIONS UNIES,
EXECUTIVE OFFICE OF THE SECRETARY-GENERAL,
New York, NY, June 25, 1985.

Mr. EDWARD R. ROYBAL,
Chairman, U.S. House of Representatives,
Select Committee on Aging, Washington, DC.

DEAR MR. ROYBAL: On behalf of the Secretary-General, I should like to thank you for your letter of 13 June 1985 inviting him to open the hearing which your Committee will hold in New York on 15 July in conjunction with the XIII International Congress of Gerontology.

As you know, the United Nations is keenly interested in the question of aging and, since 1982, has been seeking to implement the International Plan of Action that was adopted by the World Assembly on Aging in a conference which was organized by the United Nations that year. Further, you would be interested to know that the General Assembly of the United Nations discusses matters relating to the aged each year. I enclose, for your information, the resolution that was adopted at its last session.

As far as the Secretary-General is concerned, he would have been pleased to attend the hearing you are planning on 15 July. Unfortunately, his schedule calls for him to be abroad on the date in question and he will therefore not be able to accept your kind invitation. He has nevertheless asked me to convey to you his best wishes for the success of your deliberations.

Yours sincerely,

VIRENDRA DAYAL,
Chef de Cabinet.

United Nations, Agenda item 90, Dec. 21, 1984

RESOLUTION ADOPTED BY THE GENERAL ASSEMBLY [ON THE REPORT OF THE THIRD COMMITTEE (A/39/660)]

39/25. QUESTION OF AGING

The General Assembly

Reaffirming its resolution 38/27 of 22 November 1983, in which it called upon Governments to make efforts to implement the principles and recommendations contained in the International Plan of Action on Aging[1] in accordance with their economic, social and cultural systems and social values and changes, taking into account the circumstances of each country.

Reaffirming its resolution 37/51 of 3 December 1982, in which it requested the Secretary-General to continue to use the United Nations Trust Fund for the World Assembly on Aging so as to assist countries, in particular developing countries and least developed countries, in formulating and implementing policies and programmes for aging in order to meet the rapidly increasing needs of older persons,

Recognizing the role played by the United Nations and the specialized agencies through their efforts in the field of aging and the need to strengthen this role, especially at the regional level, in order to ensure the implementation of the Plan of Action and the systematic and efficient functioning of the technical advisory and co-ordination services of the United Nations,

Recalling recommendation 58 of the recommendations for the further implementation of the World Population Plan of Action,[2] adopted at the International Conference on Population, 1984, which urged Governments to make further efforts to analyse the issue of aging, particularly its implications for overall development, social services, medical care and other related fields.

Reconfirming that aging is a population issue which affects development and is affected by it,

Recognizing the increasing awareness of aging issues in many countries and of the need to provide national authorities, at their request, with technical and financial assistance in their efforts to implement policies and programmes,

Stressing the importance of the activities of the United Nations Trust Fund for the World Assembly on Aging towards the realization of the goals and objectives of the Plan of Action,

Acknowledging that aging is an interdisciplinary issue and that the United Nations and the specialized agencies must ensure a well co-ordinated international response to this question,

Confident that the first review of the Plan of Action, to be undertaken by the Commission for Social Development at its twenty-ninth session in 1985, will be of considerable value in view of further measures with regard to the question of aging,

Noting with satisfaction that the question of older women will be considered at the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women to be held in 1985,

Noting that the Plan of Action recognizes the relationship between aging and youth, particularly as it relates to intergenerational matters,

Appreciating the role of non-governmental organizations in promoting international awareness of and action on the issues of aging,

1. *Takes note* of the report of the Secretary-General on the question of aging;[3]

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[1] See "Report on the World Assembly on Aging, Vienna, 26 July–6 August 1982" (United Nations publication, Sales No. E.82.I.16), chap. VI, sect. A.

[2] See "Report of the International Conference on Population, 1984, Mexico City, 6–14 August 1984" (United Nations publication, Sales No. E.84.XIII.8 and corrigendum), chap. I, sect. B.

[3] A/39/147.

2. *Calls upon* Governments to consider the changing age structure of the population in their plans for economic and social development;

3. *Invites* Governments to retain or establish appropriate mechanisms at the national level to promote an effective and co-ordinated response to the implementation of the principles and the recommendations contained in the International Plan of Action on Aging;

4. *Requests* the Secretary-General to continue his efforts for the implementation of the Plan of Action at the national, regional and international levels and to continue to promote the United Nations Trust Fund for the World Assembly on Aging so as to assist countries in formulating and implementing policies and programmes for aging;

5. *Invites* Governments to continue, and increase when possible, their contributions to the Trust Fund and calls upon Governments that have not yet done so to consider contributing to the Fund;

6. *Requests* the Secretary-General to continue to promote the exchange of information and experience in order to stimulate progress in the field of aging, to encourage the adoption of measures to respond to the economic and social implications of aging and to meet the needs of older persons;

7. *Urges* the Secretary-General to include advisory services to developing countries that request them in technical co-operation programmes, to the extent feasible under the funding of those programmes;

8. *Also requests* the Secretary-General to continue to promote, in co-operation with the national committees concerned, joint activities in the field of aging and youth, particularly as they relate to intergenerational matters, especially during the International Youth Year, to be observed in 1985;

9. *Further requests* the Secretary-General to ensure a well co-ordinated system-wide response in implementing the provisions of the Plan of Action;

10. *Urges* the United Nations Fund for Population Activities, in co-operation with all organizations responsible for international population assistance, to continue its assistance, within its mandate, in the field of aging, particularly in developing countries;

11. *Invites* the regional commissions and specialized agencies to continue contributing to the realization of the objectives of the Plan of Action;

12. *Invites* the non-governmental organizations concerned to join in the co-operative effort to implement the Plan of Action and accomplish its objectives;

13. *Requests* the Secretary-General to report to the General Assembly at its fortieth session on the measures taken to implement the present resolution, taking into consideration the first review of the Plan of Action to be undertaken by the Commission for Social Development at its twenty-ninth session in 1985;

14. *Decides* to include in the provisional agenda of its fortieth session the item entitled "Question of aging".

Mr. PEPPER. In addition to that, we want to express our very warm appreciation to the International Association of Gerontology, its president, Dr. Ewald Busse and the chair of the North American region, Dr. Bernice Neugarten for inviting the committee to participate in this very outstanding congress, and to their staff, which has acted so valuably in putting this hearing together.

We also wish to extend the warmest appreciation to Andrew Stein for his hospitality and the assistance of his staff which has been outstanding and I'm sure deeply appreciated by all who are here.

We also wish to extend our warmest appreciation to Mrs. Charlotte Nusberg and Mary Jo Gibson of AARP's International Activities Division for their ideas and ongoing support in planning this hearing.

In our country we are far below the standards we hope to reach in providing for the elderly. As has happened in most of the countries of the world there has been a rapid increase in the percentage our elderly constitute of our population. When I was born in 1900, 5 percent of the people of the United States were over 65 years of age. Now 11 percent of our population are in that category and it is estimated that in less than 50 years almost 20 percent of our people will be in that age group. Interestingly enough, I don't know whether it's true in all the other countries of the world or not, the group of the elderly which is increasing most rapidly percentagewise, is the group over 85 years of age. I will be 85 on the eighth of September, so I rather hope that if I make that 85th birthday, I will be getting on the toboggan slide with that 85 group and may be good for a long while yet. I hope so.

Now, President Roosevelt, to whom we in our country and I think, if I may say so, many of the people of the world are so much indebted, initiated Social Security in this country in 1935. We are going to commemorate shortly the 50th anniversary since President Roosevelt signed the Social Security bill into law in 1935. That is part of a three-pronged program. There is Social Security in what we call the technical sense. We have about 38 million Americans who get a Social Security check, averaging around $400, every month. In addition to that of course, there is old age and survivor's benefits that are associated with that, aid to dependent children, educational benefits and the like, which are a part of what we call our Social Security Program.

Then in 1965 we added another prong, which we call Medicare, the design of which is to treat people who are ill. It does not give checkups, or preventive care to those who are not ill, and we think that is one of its great deficiencies. We are just beginning to allow for the checking of blood pressure to detect the possibility of the danger of stroke. Already we have diminished the number of deaths in our country and also the amount incurred as expense in hospitalization of stroke patients by virtue of that preventive action that we have taken. But Medicare, as I said, is limited, in the length of time that you may be in a hospital. A little of its aid goes to home care, not nearly enough. Many of our elderly people own their own homes. There is no reason they should have to pay rent on a hospital or on part of the space that they would occupy on some other sort of a structure, when they own their own home. Therefore, we are encouraging, as best we can, an increase in the amount of home care we provide to the elderly of our country.

Under Medicare, we provide no payment for drugs that are consumed by the elderly, and in our country the elderly need about three times as much medical care as people of younger ages. The only drugs that are paid for by the program, by public authority, are drugs prescribed by a doctor and used by the patient in the hospital. Now, the doctor can prescribe the same drugs for the same patient for home care and the patient will have to pay for the drugs. We understand the bill to be some $2 or $3 billion a year. Many of us are working to eliminate that situation at the present time.

The Medicare Program also does not include many of the severe illnesses our elderly people experience—for example, Alzheimer's disease. Dr. Robert Butler, this great American who we are so proud of, who has done so much for the cause of the elderly, was the first person I ever heard who proposed that Alzheimer's disease was not senility attributable to one's age, but in fact, an illness. He urged us to find the cause and cure of it, just as we need to find the cause and cure of cancer and the illnesses that beset our people.

Alzheimer's disease is now the fourth largest killer in the United States, and yet it's not covered by Medicare. Many families are being made destitute by their care for members of those families who are afflicted with Alzheimer's disease.

Some of us in Congress have sponsored legislation to set up a special program to deal with Alzheimer's disease, providing care as well as research in 20 different centers around the country.

There is another phase of our medical program besides Social Security and Medicare and that's Medicaid, we call it. That's a joint program between the Federal Government and the States, but to get the benefit of that program you have to spend yourself almost destitute. Under that program we provided funds for something over a million elderly people a year in nursing homes.

There are many things, therefore, to be done in our country. We are not making any effective progress in dealing with the question of long-term care. We have so many instances of elderly women who live alone, often with no place of their own to live, and they need gentle care. Many of them just custodial care and security of residence. Others need congregate living facilities and the like, but one of our great deficiencies toward which we are struggling for a solution in our country is to develop a plan of long-term care. I am the chairman of a subcommittee that works on that topic—health and long-term care. My distinguished colleague here, Mr. Biaggi has been one of the most able champions of all these programs to make life better, and care greater and more meaningful, for the elderly of our country.

This is just a little bird's eye view of our system in America. Some of us have dedicated our lives, we have prayed the utmost sentiments of our heart, that we will like to see the day in our blessed America when every man, woman and child, by paying whatever he or she can, will get the medical care he or she should have. We will not have reached, we believe, the realization of our democracy until we have achieved that. Many of you who are represented here have achieved it more effectively than we have. Therefore, we shall listen intently to what you have to say about what you have been able to do in your own many able and excellent systems throughout the world. It will be heard here this morning.

So, I have to go back to Washington. I appreciate enormously the privilege of being here with you, having some small part in this congregation and in this hearing today. I thank you for the privilege of being with you, and I thank my distinguished chairman, Mr. Roybal, for allowing me to open this hearing. I now turn the chair over to my beloved friend, the great representative from this great State of New York, and a great champion of the elderly, the Honorable Mario Biaggi.

STATEMENT OF MARIO BIAGGI

Mr. **Biaggi**. Thank you very much Senator Pepper. The Senator is most generous in his comments, but let me respond in the only way I know how. Aside from being revered and respected and loved, he is in fact America's national treasure and should be regarded as such and given all of the accolades and privileges that come with that special distinction.

Needless to say I am just delighted to be with you this morning and to participate in this important hearing. It is also a pleasure for me to welcome the delegates of the Thirteenth International Congress of Gerontology to my home city of New York. I hope your deliberations are productive, but not so time consuming as to prevent you from enjoying the many unique pleasures that this great city has to offer.

I am proud to be an original member of the House Select Committee on Aging. I also serve as its subcommittee chairman on Human Services. Our committee is, in fact, the largest committee in the House of Representatives and in our more than 10 years the committee has served as a powerful advocacy group within the Congress on behalf of our Nation's rapidly growing elderly population. I might add that the benefits that have flowed since the creation of that committee have multiplied. Clearly we are a lobbying group in the best sense of the word. We have members of that committee that serve on every standing committee. They serve as watchdogs, they are ever vigilant. Any kind of proposal that might encroach on the interest or erode the interest of the elderly are clearly dealt with and quickly. We have developed an attitude in the House that the elderly are sacrosanct, and properly so.

Today's hearing is entitled, "Continuing Care, International Prototypes for America's Need." Put in another perspective there is an old saying, that imitation is the greatest form of flattery. We will focus today on some of the more successful models employed by foreign nations to provide health and long term care services for their elderly citizens.

Some of these are worthy of the closest consideration for adaptation to our society. These might include the three tier delivery system approach as employed by countries like Sweden, Canada, and Mexico, or perhaps expanded noninstitutional care as done in Japan, or the family practice system as employed by Canada and the United Kingdom.

The point is clear, while we have many good features in our various programs to help our citizens, we should not overlook other successful approaches.

I was questioned a little bit ago before the hearing started, and asked about the progress we had made in the United States. I, together with Senator Claude Pepper, represent the United States in the First World Assembly on the Aging in Vienna, and it was, to say the least, interesting, but certainly most revealing. We in America, and I guess other countries, have kind of a parochial sense, and understandably so. But when you listen to the attitudes and philosophies of the various cultures across the world, you will understand how far we have progressed. We are not at the top of the list, but we are certainly far from the bottom. We are pretty much up there. I'll illustrate one testimony, one bit of testimony that was given. Nomadic tribes in a different part of the world treat their elderly as they have always treated them. When they feel they're a burden, they are put by the roadside, given some food, some drink and if it's cold, a blanket, and they sit there and are left to die, and the elderly folks come to understand it. They have come to accept it as a way of life, as they have when they were young, did it to their preceeding generations. Now that's, in the mind of some, barbaric.

Clearly, it's an indication of how much has to be done on an international basis, and that's why it's so important that we have this international congress here. So that we have an exchange of ideas and make us feel a little better, and also encourage the others to try to change their ways.

As I stated, I was a member of the United States delegation to the World Assembly on Aging in Vienna in 1982. As many of you know, that assembly emerged with an international plan of action on aging which recommended a wide array of approaches at the national, regional, and international level to deal with the universal challenge of a rapidly aging world population. This international congress will focus on some of the elements of this international plan of action, and the passage of time should allow some of these recommendations to reach policy fruition.

In our Nation it is safe to say that aging in America is a success story, yet to insure that it continues it is vital that the public and private sector work in a partnership on behalf of insuring that the quality of life keeps pace with the quantity of life. There is no greater challenge before us as a nation and a world.

Before I introduce our distinguished witnesses, we welcome them clearly, and we are looking forward to their contributions. We note that it will be significant and memorable.

I'd like to recognize my colleague from New York, Congressman Thomas Manton who is a freshman Congressman, but who will reveal his sensitivity with relation to the aging. The very first thing that he did when he came to Washington was to seek us out, Claude Pepper, myself, and Chairman Roybal, and ask to be appointed to this committee, first and foremost before any other committee and he has gone on to demonstrate clearly, by his activity that he is committed to the purpose of the Select Committee on Aging and the elderly, not only of our city and country, but of the world.

Congressman Tom Manton.

[The prepared statement of Representative Mario Biaggi follows:]

PREPARED STATEMENT OF REPRESENTATIVE MARIO BIAGGI

I am pleased to attend this important hearing addressing the critical issue of long-term care. Such care must provide for a population with very diverse medical and emotional needs. A wide range of alternatives in health care must be developed if we are to adequately meet the growing numbers of elderly in this country. While many programs for long term care already exist, this Nation still lacks the quality and quantity of health care for the elderly which exists in other countries.

Today we will be hearing testimony highlighting topics in health care such as medical training and research in Geriatrics, public awareness, and what other countries have done to provide the elderly with adequate health care. The American health care system today is poorly geared to the longterm care needs of the elderly. The information presented today is an attempt to analyze the present situation and to suggest possible alternatives and supplements to our existing health care policies.

One basic problem in the American health care system results from the shortage of well-qualified physicians in geriatric care. Although this country has a large number of physicians, with a total of 575,000 U.S. doctors expected by 1990, there still exists a continuing deficit in geriatrically oriented physicians. Training programs in geriatrics are scarce. Alongside the demand for more doctors is the need for more research in the medical field of Geriatrics. With the rising numbers of elderly comes the necessity of aging research, especially into prevention and treatment of devastating diseases such as Alzheimer's disease and osteoporosis.

It can be seen that this Nation must emphasize the need to create innovations in longterm care. The focus must be on how to promote the productive capabilities of older persons in our society. Using medical research and public awareness education, we must develop a more enlightened and optimistic approach to the physical and emotional situation of the elderly.

This Committee has been in the forefront of pioneering efforts to advance solutions to the longterm care needs of our Nation's elderly. I am confident that today's hearing will bring us creative solutions to this issue.

STATEMENT OF REPRESENTATIVE THOMAS J. MANTON

Mr. MANTON. Thank you Mr. Chairman. I have a brief opening statement.

I am pleased to see the Select Committee on Aging back in New York City. I'd like to commend the chairman for holding today's hearing in conjunction with the International Congress on Gerontology. Since it's beginnings, the Aging Committee has been active in the field of international health. As a new member of the Select Committee on Aging I am pleased the committee is continuing to be a part of a worldwide exchange of ideas on the issue of health care.

My district, which is just across the river in Queens, the Ninth Congressional District of New York, has one of the largest concentrations of senior citizens in the State and in fact, has the 12th largest number of seniors of all of the 435 congressional districts in the United States. I consider it a priority to insure that older Americans have access to quality health care. The Select Committee on Aging has held several hearings concerning the elderly's access to quality medical care and their ability to finance such care.

At a hearing held by the committee last week we examined the impact of the administration's cost containment measures on the quality of care given to older Americans. At that hearing providers of State and local communities discussed the problems they are experiencing in providing adequate long-term care services to our Nation's senior citizens.

In light of last week's hearing I am interested to hear the experiences of the aged in other countries. I believe it will also be informative to learn the components of the long term health care of other nations. Of particular importance are the types of alternative care methods utilized and the way they are financed. However, it is necessary to determine the ways these methods can be applied in the United States.

The United States does not have a comprehensive national policy on long term care. I believe this is a severe gap in this country's health policy agenda for the aged. Congress must take steps to help the elderly and give them access and pay for quality continuing care services. Today's hearing is an important part of that effort.

Again, I would like to commend the chairman for his leadership on this issue and I look forward to hearing today's testimony. Thank you.

Mr. BIAGGI. Thank you Mr. Manton. Joined by distinguished colleague from the State of Michigan, Representative Mark Siljander who succeeded, just for historical reference, David Stockman.

STATEMENT OF REPRESENTATIVE MARK D. SILJANDER

Mr. SILJANDER. Mr. Chairman, make sure that is just a historic reference, thank you.

Mr. BIAGGI. Any statements?

Mr. SILJANDER. No; I'd just like to say that I am sorry for being a couple of minutes late, but you know how New York shuttles are from Washington DC, always an hour late, but it's certainly a pleasure to be here and I look forward to hearing from all the witnesses, and I just want to reiterate, while Dave Stockman is making $1 million a year in his new position here in New York, I just want to emphasize that I am after his footsteps in that respect.

Thank you.

Mr. BIAGGI. As acting chairman, let me join Senator Pepper in welcoming our new staff director, Fernando Torres-Gil who came to our committee from the University of Southern California where he has distinguished himself as a leading authority in gerontology.

Another piece of housekeeping, there will be an important meeting tomorrow, Tuesday, at the United Nations, sponsored by the International Center of Social Gerontology from 10 a.m. to 1 p.m., in meeting room No. 2 of the U.N. Building. The subject is the Vienna International Plan of Action on Aging, 3 years later. For further information see Dr. Tom Mahoney in the back of the hall after the hearing.

I'd like to, reference was made to Alzheimer's disease by Senator Claude Pepper. I'd like to—for the record—state that two amendments to the Older Americans Act dealing with this problem, the first two ever, are amendments that I introduced.

One to title III-B to provide supportive services on a priority basis to families of victims of Alzheimer's disease and one to title IV, priority and grants, to train those who can provide service to families of Alzheimer's disease. It is a single step but I'm sure it's a forerunner of many others to come.

We have some welcoming remarks from some of our officials and others. The Honorable Andrew Stein, president of Manhattan Borough, chairman of Governor's Task Force on Aging, a man who has made his mark clearly, when he had the courage a number of years back to go against the establishment, formidable establishment and lay open the abuses and horrors that existed in many of the nursing homes in our State and those of us who are involved in this area of activity, are deeply grateful, all Americans should be, because absent his leadership, subject to the great peril impression, that terrible, terrible situation might have continued on.

President Stein.

STATEMENT OF ANDREW STEIN, PRESIDENT, MANHATTAN BOROUGH, CHAIRMAN, GOVERNOR'S TASK FORCE ON AGING

Mr. STEIN. Thank you very much, Congressman Biaggi, and I'd like to welcome the committee to New York, to Manhattan. Congressman Biaggi referred to Senator Pepper as a great national and world resource. Well, we consider Congressman Mario Biaggi a great national resource for the State and the city of New York and we appreciate all the great work that he does for our senior citizens. As a newcomer to Congress, Congressman Manton is also starting to be very active in the area of the elderly. We welcome the committee here to New York.

It is appropriate that the Select Committee on Aging should conduct a hearing on long-term care in this city. Our State and city governments are among the leaders in the nation in providing for alternative modes of care for the chronically ill elderly.

Some 40,000 city residents are beneficiaries of home care under a Medicaid waiver that allows payments for this essential and humane alternative to institutionalization. Nor is home care the only service offered to our elderly. Tens of thousands of New Yorkers are enriched by the most comprehensive program of senior centers in the Nation, as well as many other services that are of particular benefit to the frail and chronically ill elderly. Nevertheless, there is much to be done both here and in the Nation. I want to call your attention to one particularly glaring omission in the services available to our chronically ill seniors.

There are presently 6 million chronically ill senior citizens in America, of whom some 95,000 in New York State and up to 3 million nationwide are suffering from Alzheimer's disease and related disorders. These seniors are often cared for at home by family members who are themselves elderly and sometimes frail. They perform this loving care even though many of them get no respite, no counselling, and no financial assistance of any kind from government or private insurers.

These family members are the front line of this country's primary care providers for the chronically ill aged. Contrary to widespread myth that Americans abandon their aged relatives, families actually provide 80 percent of all the health and social services needed by the elderly.

But now the American family needs help. Those who find themselves caring for victims of Alzheimer's or other serious chronic illnesses at home are damaging their own health and well being because of the unremitting course of this disease and the virtually around-the-clock diligence it requires to the caregiver.

Unless the government and the private sector start providing some help to these families, that essential front line in our treatment of the chronically ill elderly will start collapsing. This is already a pressing national health problem. It will reach emergency proportions by the year 2000, when we can expect 6 million Alzheimer's victims and an overall total of well over 9 million elderly with serious chronic illnesses.

One way of meeting that challenge is through the development of day treatment centers. I believe that as Americans begin to confront the consequences of the demographics of aging they will recognize that community based day treatment centers are an absolutely essential component of the continuum of services required by chronically ill senior citizens. Such centers can provide physical and social therapy for the patient, but perhaps most importantly, they also provide aid for the hardpressed family caregiver.

We will not be able, nor should we want, to provide enough nursing home beds for all the millions of additional chronically ill elderly by the year 2000. But providing the respite needed by family caregivers through day treatment center is both logical and humane.

It will help make it possible for millions of families to keep their elderly loved ones at home instead of in the nursing home. That is why I wholeheartedly support the bill recently introduced in Congress by the distinguished chairman of this committee, Representative Edward Roybal.

Drafted in close consultation with the Alzheimer's and Related Disorders Association, this legislation would expand Alzheimer's research, establish public education programs, and provide funding for model day care treatment programs. The emphasis in this bill is on creativity, with States being urged to devise innovative and cost effective day treatment programs which would be replicated throughout the country. This is a challenge now confronting all of us in public life who care about the quality of life and wellbeing of our elderly fellow citizens.

The Older Americans Act of 1980 pioneered the development of senior citizen centers in all our communities throughout the country. The next item on the agenda is to develop Federal, State, and private-sector initiatives to create similar centers for those of our aging citizens who, unfortunately, suffer from chronic illnesses and deserve to live in dignity in their own communities.

In these hearings you will be hearing testimony about how other Western democracies are coping with long term care needs in their own aging societies. We here in the United States have a great deal to learn from them. We pay more per capita for health care than any other nation, yet our public health care statistics leave much to be desired.

Certainly we can learn a great deal from the experiences of those countries such as Germany, Denmark, and England, where comprehensive long term care services for the chronically ill elderly include day treatment centers. Such care is a recognized government responsibility. I thank the representatives of those countries who have come here today to give us the benefit of their experiences. And again Congressman, I wish to thank you very much for allowing me to speak today.

Mr. BIAGGI. Thank you President Stein. Once again, let me thank you for your hospitality.

It is a special privilege and an honor to introduce a dear and valued friend as well as a most distinguished public servant, Councilman Jerry Crispino. Jerry served with special distinction as chairman of the health committee of the New York City Council. This is an important committee, especially for the 1.3 million elderly of our city.

Jerry works closely with me in Congress, not because we both represent the Bronx, but also because of our shared concern for the elderly. There must be a partnership between all levels of government to insure high quality care for the elderly. Jerry Crispino plays a key role in this partnership. Mr. Crispino.

STATEMENT OF JERRY CRISPINO, CHAIRMAN, HEALTH COMMITTEE, NEW YORK CITY COUNCIL

Mr. CRISPINO. Good morning. Thank you very much my good friend Congressman Mario Biaggi, Senator Pepper, of course it was indeed a pleasure to meet and greet him in our city, and my former colleague in the city council, it's wonderful Tom, to see you as a member of Congress in action and of course here in our great city.

Mr. Manton. Thank you Jerry.

Mr. Crispino. As chairman of the Health Committee for the New York City Council I am pleased to welcome the delegation of the Thirteenth Annual Congress of Gerontology and I would like to commend you on your selection of New York City for this meeting.

This city has among it's citizenry of course more than 1.3 million persons over the age of 60. We understand that today's hearings will focus on continuing care and will examine international prototypes for America's aged. I commend the House Select Committee on Aging for dedicating a hearing to this topic, and it's clear that whether you are a council member for the city of New York or a Member of the House of Representatives in Washington, that one of the greatest challenges we have before us now is how to cope with the rapidly increasing aging of our society and how to help this segment of our society.

In the State of New York we have seen a 12-percent increase in the number of persons aged 65 or over just since 1970. Naturally we find that 26 million persons are over the age of 65 and that the number is expected to grow to 35 million by the year 2000. The challenge before us is to insure that the health and long term care and appropriate social and human services are available to those elderly in need.

It is a challenge which must be answered within fiscal reality and responsibility. Inevitably we must look to establishing a partnership. In the public sector all levels of government must work together. We must see public-private sector partnerships and of course, as your delegation well knows, we have an international partnership. Today's hearings and your meetings comprise one important element of that partnership, an exchange of ideas and thoughts.

In my capacity as chairman of the health committee of the city council I am deeply concerned about the quality of care for senior citizens in our city. We are fortunate to have a diversified and effective health care delivery system.

We are advanced not only in the provision of institutional care but also the all important alternative to institutionalization. I am a firm supporter of the need to expand home and community based care for seniors, and will continue my efforts in this regard.

I want to thank you Mr. Chairman for the opportunity given me today to appear here before you and your committee, to welcome you, the committee, and all of those who have come to our great city to participate.

I also am indeed personally pleased and it's always a pleasure to meet with you socially and of course in my capacity as chairman of the health committee, and on a personal basis I would like to point out that just last year we were especially fortunate in knowing that although you have served for over 10 years as a member of the House Select Committee on Aging, that you successfully added $15 million for vitally needed funds for the home delivered meals and transportation of services for the elderly.

I want to salute you Congressman Biaggi, both as a friend and as a member of government here in the city for all you have done, and I would like those who do not know, that we both served in the northeast Bronx and have served that community and I hope that I will continue to have the pleasure to see you serve far many more years than Congressman Pepper has served, because I know you have great vitality and energy, and God bless you.

Mr. BIAGGI. Thank you Jerry. There is only one Claude Pepper, Jerry. Dr. Ewald Busse, president of the International Association of Gerontology, an associate provo and dean of Duke University, and a man who is responsible for our being here and we thank you very much for all of your cooperation and assistance, and also Dr. Bernice Neugarten, chairwoman of the North American region.

STATEMENT OF EWALD BUSSE, M.D., PRESIDENT, INTERNATIONAL ASSOCIATION OF GERONTOLOGY

Dr. BUSSE. Thank you, sir. Mr. Chairman, members of the committee, distinguished witnesses and ladies and gentlemen, The Congress is very pleased that this hearing is being held at this time because those of you who are not thoroughly familiar with the Congress should understand that the Congress is very concerned about the health and well being of the elderly, not only in the United States, but throughout the world.

The Congress actually is made up of representatives of over 50 nations and as of this morning there are over 3,000 delegates at this congress. You should know that the International Association of Gerontology which sponsors this congress is really made up of nations and we are pleased to say that six new nations have applied for membership in the IAG.

I should also recognize, because it was mentioned by our distinguished chairman, that the United Nations is involved in our activity and it stems of course from the assembly which he attended in Europe a few years ago. We have had financial support from the United Nations, from the World Health Organization, from the Pan American Health Organization, from the National Institutes of Health, and particularly the National Institute of Aging and numerous private foundations and corporations. This is why it is possible for us to bring these participants here particularly from the developing nations, because I think you can appreciate that their financial resources are limited.

I understand that we must address the problem of continuity of care and try to gain some knowledge from the other developed nations, but I want to remind you that the developing nations are rapidly facing a very serious problem, and we too must stand ready to assist them by demonstrating our capacity to handle this problem and by developing adequate models so that they can find a reasonable way within their financial limitations, to pursue this mounting problem.

I do not believe it would be appropriate for me to make any further remarks for the simple reason that the distinguished witnesses that you will be hearing will not only bring you the best information available but I can also assure you they will present it in a very, very clear manner.

Thank you for this opportunity to be with you. I look forward to hearing.

Mr. Biaggi. Thank you very much. It will be the procedure this morning to hear all the testimony from both panels and members of the committee will refrain from asking questions until the testimony is completed and we acknowledge for the record the testimony by Drs. Robert and Rosalie Kane of the Rand Corp., California, and Dr. William Glaser, New School for Social Research.

The first panel to discuss cross national issues, Mrs. Birte Codel, citizen of Denmark, residing in United States.

Mrs. Codel. Thank you.

Mr. Biaggi. Let me announce all the witnesses. Mrs. Betty Havens, provincial gerontologist, Manitoba, Canada; Mrs. Sally Greengross, deputy director, Age Concern, England, secretary general, International Federation on Ageing; Dr. Franz Baro, director, University Psychiatric Center, Catholic University of Leuven, Belgium.

Panel No. 2, implication for the United States: Dr. Robert Butler, Brookdale Professor of Geriatrics and Adult Development and chairman, Gerald and May Ellen Ritter Department of Geriatrics and Adult Development, Mt. Sinai School of Medicine, New York, former Director of the National Institute on Aging; Dr. Alice Rivlin, director of economic studies, and Mr. Joseph Wiener, both of the Brookings Institution. Dr. Rivlin was formerlly the Director of the Congressional Budget Office.

Ms. Codel.

STATEMENT OF BIRTE CODEL, CITIZEN OF DENMARK RESIDING IN THE UNITED STATES

Mrs. Codel. Mr. Chairman and the Select Committee on Aging. Thank you for the opportunity to appear before you today to talk about the experiences of my late parents in Danish nursing homes.

I am a Danish citizen, married to an American and with two American children. I have lived in the United States for the past 11 years.

My mother was born in 1905 and died in 1980 during a party at her nursing home honoring her 75th birthday. My father was born in 1897 and died at a residential facility at the age of 85 in 1982.

They had lived in a modest, single-family house just outside a small city west of Copenhagen. My mother had been ill for several years and in order for her to stay at home she had a nurse come daily to give injections and help with personal hygiene. This service was paid for entirely out of public funds, at no cost to my parents.

She also had a home helper for a few hours each weekday to help prepare meals and do general housekeeping. This service was provided by the local government at a nominal fee.

In 1976 my mother had one leg amputated and was no longer able to live at home. The surgery was performed at public cost and as is the norm in Denmark, convalescence took place in the hospital where the surgery was performed.

After convalescence mother was admitted to the local nursing home. It was the equivalent of an American intermediate care facility.

She had a corner room with plenty of light. The room was furnished with her personal furniture except for the bed. She needed a hospital bed. She had a private phone line at her own expense.

Mother got around in a wheelchair. She was able to take advantage of the residents' kitchen down the hall. She invited friends for the traditional afternoon coffee. She would roll down to the kitchen to prepare the coffee, bring it back to her room and serve it to her guests.

She could also invite dinner guests as long as a friend or family member was willing to help mother prepare the meal in the kitchen.

My father was able to stay at home for another year, aided by a home helper.

About a year after my mother's first ampution, her other leg was removed. It became obvious to my father that she would never be able to live at home again. The house was sold. Father moved into sheltered housing, the equivalent of an American residential care facility. He had his own room with his own furniture. He had access to a bathroom and kitchen. He was responsible for his own personal hygiene, his laundry and showing up in the main dining room at meal times. He was able to walk to the nursing home daily to visit mother. He died in 1982, still a resident of the sheltered housing facility.

I know that both of my parents were satisfied with their care and surroundings. There was no direct expense to either of them. About half of their state pension, the equivalent of Social Security, was deducted to cover the cost of their care. That is standard policy. There is no means test or famililiy responsibility in Denmark, and the proceeds from the sale of their house went entirely to them.

Please bear in mind, however, that my parents did pay, and all other Danes do pay, an average of 52 percent of their gross income in taxes to support this system.

For my part I maintain my Danish citizenship as a security blanket. If and when I become old and frail or in need of long term care, I would much prefer to be in a Danish nursing home. To me they are much more home-like and less institutional than American nursing homes. I prefer the peace of mind knowing that I could not possibly be a financial burden to my family.

I have visited many American nursing homes. Maybe their Danish equivalents would not meet all the standards and regulations to which American facilities are subject, but they do meet Danish requirements. Based on my parents' experiences and what I saw while living in Denmark, that's good enough for me.

Thank you Mr. Chairman, for the privilege of speaking here today.

Mr. BIAGGI. Thank you Ms. Codel. Ms. Havens.

STATEMENT OF BETTY HAVENS, PROVINCIAL GERONTOLOGIST, MANITOBA, CANADA

Ms. HAVENS. Thank you Mr. Chairman. It is my pleasure to attempt to elucidate some of the similiarities and dissimilarities in the practice, financing, and delivery of continuing care in Canada, more specifically in Manitoba and in this country. There certainly are differences, but I believe that the similarities in our two systems, our two cultures and our two countries far outweigh the dissimilarities. I also wish to note that I do not plan to repeat previous testimony from Dr. Rosenfeld,[1] and others which this committee has heard, therefore, I will assume that the committee members are generally knowledgeable about both the Canadian health care system and it's application to our aging population.

I also wish to indicate that I am especially pleased by the title of this hearing, that is, "Continuing Care." My pleasure on this latter point stems from the fact that our integrated provincial program for community based home care and personal care home—or what you refer to as nursing homes—placement system is called Continuing Care.

Our Manitoba Continuing Care Program is a province-wide universal, no cost to consumer program which was initiated by the Provincial government in 1974 and gradually expanded throughout the Province by 1975. This program assesses persons requiring care whether for placement in our publically insured personal care homes or for home care. The program also delivers services to those who remain at home on the Home Care Program. Therefore, there is neither financial incentive or disincentive to use one component of the program as opposed to the other.

The program is based on professionally coordinated and conducted assessments of need, care planning and supervision of service delivery. Each potential client, regardless of referral source, is assessed to determine the need for services based on a clinical, health functioning and social functioning assessment. The assessment is to include identification of those activities which the person can perform, those which family members, friends or neighbors can realistically perform, and those which require the initiation of formal services. The ability of the assessment to identify strengths initially and then to proceed to identifying weaknesses which may inhibit independence, allows the assessment team to develop a care plan and assign a case coordinator which will provide only those services which support independence.

If the Chair wishes I would be pleased to provide the assessment instrument to the committee.

Mr. BIAGGI. Thank you, we would appreciate that.[2]

Mrs. HAVENS. Services provided by the program are to be the minimum required to meet the needs and to foster independence. Delivery is organized so that services are provided by the person with the minimum skills required to perform the task.

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[1] See "International Perspective on Health Care: Learning From Other Nations," pps. 16-29, 57-59, 61-63, 74-76, a Select Committee on Aging hearing held May 1, 1984. Comm. Pub. No. 98-450.

[2] See app. 2, p. 81 for additional material submitted by Ms. Havens.

When a common assessment process is used across all sectors of long-term care and when the assessment itself is designed to establish types and amounts of care required, the last step in the process is to determine the most appropriate location for that care. That is, only after all the strengths and weaknesses of the client and the informal support network have been adequately assessed does the assessor begin to consider the site of care. In other words, the last decision to be made must be the site or location. That is, whether it's in own home, family member's home, children's home, personal care homes, or any of the other various residential alternatives. In any case, the decision about location must be made last. If the location decision is made first, it begins to drive the whole system.

What one really needs to know is not whether or not the individual is eligible for nursing home care, although that is the usual argument, but rather whether or not the individual needs a level of care equivalent to nursing home care, regardless of it's source. Two different decisions are involved. That is the assessed need, type, and level of care decision, which is very, very different from the location or site of care decision.

As you are already aware, the Canadian health care system is really 10 provincial systems which have many components in common and even more variations. The Federal Government sets certain guidelines and standards to which they link their financial contributions to the various provincial health care insurance plans and programs. Further, in keeping with Federal policy priorities, the contributions vary across programs. In view of the ultimate source of these funds, that is the Canadian taxpayer, this may seem unimportant. However, it does make a big difference because the various funding formulas determine the amount of taxes that must be raised directly within each province, similar to your States. Therefore, the provincial share of the health care costs is determined according to these formulas.

In Canada, therefore, we often refer to health care dollars according to the Federal provincial sharing formula. For example, 50-cent dollars. A 50-cent dollar would mean that the province is contributing 50 cents and the Federal Government the other 50 cents. Seventy-cent dollars means that the province is contributing 70 cents, Federal 30 cents. Because these cost sharing formulas vary across programs, programs may be reduced or modified, or even eliminated in order to reduce the provincial share of the health care costs. For example, most nursing home dollars are 60- or 70-cent dollars, but welfare system based facilities are usually 50-cent dollars, while the chronic hospital programs tend to use 40-cent dollars. Therefore, it costs the provinces more for nursing homes than for hospitals. Given this situation, if home care programs are established from hospitals, they will be less costly to the province than those attached to nursing homes or in the welfare system, or if they are community based, in a global provincial grant with the approximate level of 50- or 60-cent dollars.

As you can appreciate, these sharing arrangements are important because of the differences they produce in the ways in which programs tend to develop. That is, a hospital-based program will be more likely to place an emphasis on acute care, as hospital replacements, than will a community-based home care program. In the latter case, home care will be more likely to reduce the demand for nursing homes in the face of an increasingly aging population.

In any case, the individual and his or her family are not subjected to either financial insecurity or insolvency as a result of chronic disease in those provinces which insure nursing home care and either insure or provide home care. It is true that more tax dollars are invested in the health care system than is true in the United States.

You are likely concerned—like most of my friends in the States—who ask me whether or not families will dump their older family members into a home care program or into an insured nursing home. In other words, as I understand the position of those persons who are opposed to publicly insuring or subsidizing long-term care, there is a fear that families will neglect their familial or financial responsibility for their older members.

I consider home care as the most enabling of programs to ensure that families can and will continue to care for older family members, and universality of home care and insured nursing home care is a further guarantee of support by families, not a deterrent. In Manitoba, 80 percent of the care provided to persons over the age of 65 is still provided by the family and/or members of the informal support system. This rate was 80 percent before home care was introduced. It was 80 percent before the insured nursing home program was introduced, and it is still 80 percent. As a matter of fact, there are many elders whom it is hard to believe are able to be maintained in the community. Two of the most widely used program components in our system are the adult day program and the respite program. With these programs families continue to cope with their elderly relatives, including those with Alzheimer's disease, as do neighbors and friends. Nursing home staff are often amazed by the ability of families and neighbors to cope with such heavy care. We have had ample opportunity to observe that this formal care has supported the informal care system, not detracted from it.

Finally, if I may sir, I'd like to make one more point. If there is one thing that we have learned in the Manitoba Continuing Care Program during the past decade, it is that it is absolutely critical to have sufficient professional program staff trained in assessment in all geographic areas. If caseloads become unrealistically large, it inhibits prompt assessments, slows down case reviews, mitigates against appropriate and timely reassessments, and precludes innovative solutions. This can incur client dependence through delays in removing unneeded services or in decreased cost effectiveness. The client may become frustrated, families will become frustrated, and they will use care facilities more quickly when the community care system is not being responsive to their needs. Also, the easy decisions will be made, and it is always easier to place someone in a nursing home than it is to coordinate services in the community from multiple sources. Therefore, if staff levels are not maintained the program will cease to be effective and efficient and will become more costly. There are no shortcuts to adequate staffing which is required to maintain a continuing care program, in terms of assessment, reassessment and coordination of services.

Thank you for your interest in our health care program.

[The prepared statement and attachments submitted by Ms. Havens follows:]

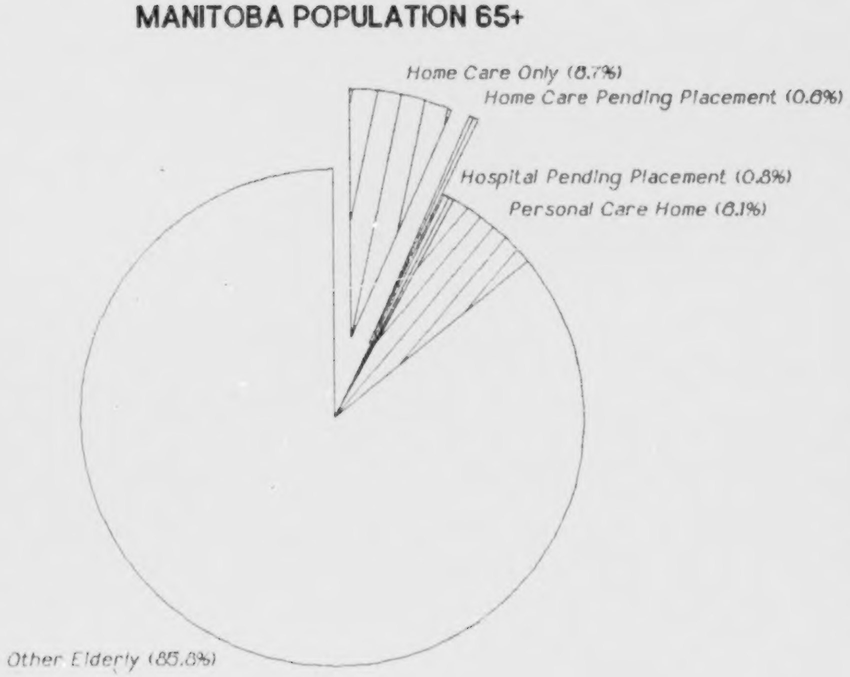
PREPARED STATEMENT OF BETTY HAVENS, PROVINCIAL GERONTOLOGIST, MANITOBA, CANADA

In preparing testimony for the Select Committee, it seemed most appropriate to abstract two recent documents which were prepared for a general audience to explain the Manitoba Continuing Care Program after a decade of experience. These abridged papers: "Boundary Crossing: An Organizational Challenge for Community-Based Long-Term Care Service Agencies" and "A Long-Term Care System: A Canadian Perspective" follow immediately after this introduction. The references in the first paper ("Boundary Crossing") may also be useful in the Committee's deliberations. Four items from this list which are particularly difficult to obtain (1983 and 84 Manitoba Department of Health Annual Reports, the Ewanchyna, Collins and Black 1978 paper, and the 1982 Manitoba/Canada Home Care Report) have been submitted together with the Assessment and Statistical Reporting Forms and Policy Manual for the Manitoba Continuing Care Program as a part of this statement for use by the Committee.

The population of Manitoba is slightly over 1,000,000 with over 600,000 living in the capital City of Winnipeg. The population of Seniors (65+) represents approximately 12 percent of this population. In order to provide a brief overview of the present (1984/85) statistics for users of long-term care, I believe Figure 1 may be helpful as it shows the relationship of in-home and in nursing home users and those waiting placement as a portion of the total population 65+. This is further detailed in Tables 1 and 2 which deal with the Home Care Caseloads from 1982/83 to 1984/85 and the 1984/85 Admissions to Personal Care Homes (Nursing Homes).

Finally, as most people also want to know more about the costs of these programs, you will find Table 3 which presents a summary of Personal Care Home per diem rates. These rates may be compared to Home Care costs during the same period. The costs per person served have been calculated in two ways. A cost per person per month figure of $142.43 was calculated using the average of the maximum number served in the month for 1984/85. A cost of $992.53 per person for the year was calculated using the number at the beginning of the year plus admissions. The costs for last year of $21,211,400.00 do not include some of the direct service costs which are now related to term positions and the cost of medical supplies from the Medical Supplies and Home Care Equipment Branch. Costs for hospital coordination and homemaker coordination are included. Table 3 and the above calculations continue to support the findings of the *Manitoba/Canada Home Care Study* that home care is a less costly alternative than institutional placement in those cases where non-institutional locations for care are appropriate.

FIGURE 1



N	
8625	Home Care Only
826	Home Care Pending Placement
974	Hospital Pending Placement
7898	Personal Care Home
111145	Other Elderly

Note: Population figures are from the Manitoba Health Services Commission. The P.C.H. figures are personal care home residents age 65+ as of March 1984.
The Home Care figures are caseload figures age 65+ as of December 1984. The waiting list figures are December 1984. There were 206 people waitng placement who were in the community but not on The Home Care Program.

TABLE 1.—HOME CARE CASELOADS

	1982–83	1983–84	1984–85
March 31	10,631	10,933	11,848
Percent change		2.8	8.4
Yearly admissions	9,696	9,761	10,438
Yearly discharges	9,202	9,479	9,549
Total receiving	19,716	20,392	21,371

TABLE 2.—MANITOBA PERSONAL CARE HOME FIRST ADMISSIONS, YEAR 1984–85

Region	From community	From hospital	From other	Total
Westman	132	141	2	275
Eastman	37	33	0	70
Central	88	72	2	162
Interlake	64	60	0	124
Parklands	44	53	0	97
Norman	27	6	0	33
Winnipeg	498	455	12	965
Manitoba	890	820	16	1,726

TABLE 3.—A SUMMARY OF THE HIGHEST PER DIEM RATES [1] EXPERIENCED IN EACH REGION FOR 1984–85

	Level 1	Level 2	Levels 3/4
Nonproprietary personal care homes:			
Central	$39.15	$51.10	$65.15
Eastman	31.70	50.45	64.30
Interlake	33.05	50.80	67.50
Norman	32.95	50.30	67.30
Parklands	44.70	55.60	71.10
Westman	37.20	57.00	73.05
Winnipeg	40.10	55.90	73.85
Proprietary personal care homes:			
All regions	[2] 46.05	46.05	63.70
Facilities opened in 1980–81		54.93	72.58

[1] The per diem rates listed are gross rates; i.e., include the residential charge ($14.75 per diem) payable by the resident.

[2] Proprietary personal care homes are required to staff for any Level 1 residents in their facility as though they were assessed as a Level 2.

[See app. 2 for additional material submitted by Ms. Havens.]

Mr. BIAGGI. Ms. Sally Greengross.

Ms. GREENGROSS. Thank you.

STATEMENT OF SALLY GREENGROSS, DEPUTY DIRECTOR, AGE CONCERN, ENGLAND, AND SECRETARY GENERAL, INTERNATIONAL FEDERATION ON AGEING

Ms. GREENGROSS. Thank you. First Mr. Chairman, may I say what an honor it is to share some experiences with you this morning. In the short time available I will concentrate on a few approaches which may be of interest to you and which you may wish to pursue further.

As the proportion of people of 75 and over is growing, the number of those needing long-term care will grow commensurately.

Increases in the number of institutions, particularly nursing homes in the United States, is likely, I understand, to be severely limited and most elderly people, in any case, express the wish to remain living in the community. That is, in their own homes. It is imperative therefore. to find alternatives to institutional care, alternatives which are of similar or lower cost, at least on an individual basis. It would appear logical to place a greater emphasis on early intervention to avoid the necessity of moving people into institutions simply because the stamina and will of their caring families are exhausted, and they have reached a point when they refuse to continue caring under any terms. The cost of preventive community care taking place now must be set against future institutional costs which might be avoidable. I will look at four different approaches.

The main emphasis on the first examples is on innoviate, relatively low cost care in the community, and this we call short-term family placement schemes. The main features of this approach are family respite through placing frail, elderly people in individual homes for short periods. This means that the local neighborhood is brought into the caring network. Old people are placed with others who very often have spent many years caring for their own parents, or perhaps have a nursing background and who find fulfillment in this work they can undertake from home. Many long term friendships are built up, but there is need for careful matching and continuous support of both the old person and the carer through a qualified coordinator, usually employed by the social services department, sometimes by a voluntary organization.

The cost of this care is covered by central government funds or local authority funds, unless the individual has a high-income, but this is seldom the case with this sort of care. It's important that the short-term care is paid so that all costs are covered, but this is not a for-profit type of work. The atmosphere is homely, the stay takes place after gradual introductions, and can accomodate amazingly high levels of frailty, as the stays are of such limited duration. It provides a fairly normal environment with personal, individual care. It gives an opportunity for carers to continue using their skills, but it must be noted that they often make a very high voluntary input, over and above what they agree to take on.

It provides, an addition to the range of options available to elderly people, reduces pressure on the scarce resource of short-stay care in homes, and prevents or postpones long term institutional care. The cost per week of keeping someone in a short-stay family home, to pay for their food and so on, would now be in the range of $70, so it's very, very low cost.

My second set of examples also involve bringing the wider community into the caring network. Here however, the emphasis is on keeping people at home through bringing to them individually tailored packages of care. A feature of these schemes is that responsibility for budgeting for and purchasing key elements of the care package is devolved to staff at practitioner level. That is away from middle or top management, thus increasing job fulfillment for those people working with frail or elderly people, which is an important enough and neglected point, and provides a named or key worker.

In Kent, England, the community care schemes allow a social worker to purchase a range of domiciliary services as a package of up to two-thirds the cost of putting a person into an institution. This is measured in revenue cost only. Papers which give details of these schemes will be submitted to you, Mr. Chairman.

[See app. 1, p. 57 for material submitted by Ms. Greengross.]

Ms. Greengross. Another similar example is a joint action research project of home support of elderly, mentally frail people, that is demented old people, which is run by Age Concern and Guys Medical School in London. Here the range of statutory, domiciliary services is supplemented by what we call good neighbors. These are paid, local people, willing to give whatever extra support is considered necessary and this extra support is assessed by the coordinators, the practitioners, while the medical assessment and social work assessment is done by the statutory authorities.

These people will give whatever is needed, and in 24 hours, however much the statutory services provide, this can often leave up to 18 hours of unsupported living, and the help offered by these good neighbors ranges from reminders to take pills to the whole range of personal care, toileting, feeding, putting to bed, and so on.

The findings are that the cost is similar to that of institutional care, but it works for anybody who can manage the night alone, and it gives greater quality of life and can postpone hospitalization right up until the time of death.

It is also showing us limits to this form of care, when it ceases to be humane and suitable; and it's a way of insuring that people do go into institutional care go because of deteriorating health, not following a crisis in their care pattern. It also indicates that early referral would be better and more effective than people when they reach a stage of heavy dependency when this type of system is not always effective and is more costly often, than hospital care.

Another London borough found similar results and satisfaction in substituting funds previously designed for residential care to this type of system when intensive extra care was provided by domicilary workers supplementing the local statutory services. The costs were lower, management was involved, satisfaction at all levels is higher, and so I think these are a set of schemes worth considering.

Another scheme you might be interested in is a new innovation in Denmark, which involves 24 hour mobile nursing home services. This is an alternative to nursing home care for very frail old people, and it's linked to a sophisticated alarm system. It means that emergency nurses with full home equipment will appear in approximately 10 minutes from a call. The savings are considerable. It's been found that the cost annually of this system is less than half of a person in a nursing home. Less than a quarter of hospitalization, and it would indicate in forecasting a decline in the numbers of having to be admitted to nursing homes by nearly a half, and also decline in the use of beds in hospitals.

My third pair of examples is about blurring the boundary between an institution and the local community it serves, and should be a part of. In Paris and in France a voluntary society has purchased a large apartment overlooking the River Seine where old people discharged from hospitals can live with their spouse for 5 or

6 weeks to become reaccustomed to living in a domestic setting. This is invaluable after serious hospital treatment.

A British form of care which is widely used and which you might also like to consider is what we call a day hospital. Part of the public hospital resource used for day care with high quality rehabilitation and treatment plans, which can avoid institutionalization and provide respite care enabling very frail old people to stay at home.

These are different from your day centers or senior centers because of the treatment involved. One such day hospital in a poor area of the city of London has developed this into a night time care facility for it's day time users when they want it for respite or additional rest purposes.

Another point is to convert residential homes into short stay homes for respite care. If this is done with the entire home it is found to be very successful, rather than mixing long-term and short-stay respite care in one home.

Last I would recommend for your consideration two particular points, if I may. Recent legislation is being prepared in the Netherlands now. It will mean that new applicants for a license to run a nursing home or a residential home will have to offer facilities to the wider community. This should break down some of the barriers between the institution and the wider community. It may be that the American system could adapt this in some form and lead the way to institutions becoming resource centers for local people who would be able to take meals, join in activities, or perhaps hold their own meetings in the home, and generally bring life to and draw on the resources of people in those homes.

Second, I venture to suggest that you give consideration to broadening the criteria for what I believe you call the waiver. Currently I think it's restricted, the way I understand it, is to people whose domicilary services are brought in only because otherwise they need immediately to go into a nursing home. If you could consider a more preventive approach through this system, or some form of block grants, and earlier precrisis intervention as an explicit policy of long-term community care, I believe you would find the above examples and many similar ones both humane and cost effective in the long term, avoiding future expensive hospitalization, continuing institutional living, and above all, it might offer a range of additional methods of serving the express needs and interests of the growing numbers of very old people among us, many of whom, of us here, who may be fortunate enough to number among them ourselves.

Thank you Mr. Chairman.

[Written questions were submitted to Ms. Greengross by the committee and the following answers were subsequently received:]

Question. Those who argue against publicly financed family support services in the US do so on the grounds that these services will supplant rather than support the family's natural role in caregiving. Has this been the case in countries with family support services in place?

Answer. Research undertaken suggests that in most industrialized countries the proportion of people in institutional care of any kind has not increased over the last century. Considering the fact that people are more mobile than they were, this indicates very strong bonds and family ties. However the caring task and the expectation placed on families has increased. This is partly because of the diminishing number of children in families and the medical advances which have made it possible for people suffering from chronic disease to remain alive for many years. It is quite common place for people to care for chronically sick and disabled relatives for a period of 15 or 20 years. Family support services encourage families to continue the caring role which, on the whole, they have taken up willingly. It is not advisable to force families to care because if this is done through duty rather than devotion the risks to the elderly person are obviously greater and we are increasingly becoming aware of the dangers of old age abuse. With adequate support, respite care and a feeling that a carer is not marooned in a solitary task which is never-ending, family care can be enhanced, maintained and encouraged and the evidence is that this is the case.

Question. What, in your experience, are the two or three most critical inhome services for persons wanting to remain at home and their families?

Answer. Day Care, provided in a flexible manner with hours that correspond to the needs both of elderly people and their carers;

Day Hospitals, with built-in rehabilitation and treatment — again with flexible hours where possible;

Respite Care, in particular short-stay accommodation so that carers can retain some degree of normal social life.

Question. To what extent are families in other countries protected against the emotional and financial burden of caring for a physically dependent elder at home? How does this compare to the US and how might the burden be relieved?

Answer. In the United Kingdom an attendance allowance is available to elderly people who require constant care in the day at a level of UK h28. This is at a higher level if day and night care is needed. An invalid care allowance is available for carers, unless they are married or cohabiting women, and the rationale underlying this discriminatory practice which is soon to be tested on the grounds of the European Community directive on equal treatment for women is that single women and men will have given up a job in order to care whereas married women will have been at home in any case. This is not the situation realistically in the United Kingdom. There is a range of support systems provided by health and social services including respite care but certainly not sufficient to enable people to take on a caring role in the secure knowledge that the burden will not become overwhelming. A system of rationing obviously exists as it must in a time of shortages but could be improved if a duty to care was placed on the local authority obliging them to provide the sort of care for elderly dependent people that is required for children who are at risk.

[The prepared statement of Ms. Greengross follows:]

PREPARED STATEMENT OF SALLY GREENGROSS, DEPUTY DIRECTOR, AGE CONCERN, ENGLAND; AND SECRETARY GENERAL, INTERNATIONAL FEDERATION ON AGEING

Firstly, may I say what an honour it is to share some experiences with you this morning. In the short time available I will concentrate on a few approaches which may be of interest to you and which you may wish to pursue further.

As the proportion of people of seventy-five and over is growing, the numbers of those needing long term care will grow commensurately. In most industrialised countries, for reasons related both to policy and resources, increases in the numbers of institutions, particularly nursing homes, is likely to be severely limited and most elderly people express the wish to remain living in the community, i.e. in their own homes. It is imperative therefore to find alternatives to institutional care, alternatives which are of similar or lower cost, at least on an individual basis. It would appear logical to place a greater emphasis on *early* intervention to avoid the necessity of moving people to institutions, if the reason they enter them is because the stamina and will of their caring families are exhausted and they have reached a point when they refuse to continue caring under any terms. The cost of preventive community care taking place now needs to be measured against future institutional costs which might be avoidable.

I will look at four different approaches. The main emphasis in my first examples is on innovative, relatively low cost care in the community:

1. *Short term family placement schemes (United Kingdom):* The main feature of this approach is family respite through placing frail, old people in individual homes. This means that the local neighbourhood is brought into the caring network. Old people are placed with people who very often have spent many years caring for their own parents, or who have a nursing background and who find some fulfilment in this type of work which can be done from home. Many long term friendships are built up but there is a need for careful matching and continuous support of both the

old person and the carer through the employment of a qualified coordinator, usually employed by the social services department, sometimes by a voluntary organization.

The cost is covered by central government or local authority funds unless the individual has a relatively high income, and in this form of care that is seldom the case. It is important that the short-term carer is paid so that all costs are covered but that this activity does not become for profit type work. The atmosphere is homely, the stay takes place after gradual introductions and can accommodate amazingly high levels of frailty as it is of limited duration. It provides a normal environment with personal individual care: It gives an opportunity for carers to continue using their skills but it has to be noted that the voluntary input that they tend to make may be very high. It does provide an addition to the range of options available to elderly people, reduces pressure on the resource of short-stay care in homes and is one way of preventing or postponing institutional long-term care. The cost per week of keeping somebody in a short-stay family home, i.e. the cost of their food and lodgings would now be in the range of $70 approximately.

My second set of examples also involve the wider community in the caring network. Here, however, the emphasis is on keeping people at home through bringing to them individually tailored packages of care. Another feature of these schemes is that responsibility for budgeting for key elements of the care package is devolved to staff at practitioner level; that is away from middle or top management, thus increasing job fulfillment for those working with frail, elderly people—an important, often neglected point. It provides a named or key worker and people tend to relate more easily to one person.

In Kent, England, the Community Care Scheme allows a social worker to purchase a range of domiciliary services, paid for and provided by the local authority social services department, as a package of up to approximately two-thirds the cost of putting the person into an institution run by the local authority. This is measured in revenue, not capital cost.

Another example of this approach is a joint action research project of home support of elderly, mentally frail (demented), old people. This is being carried out by Age Concern and Guys Hospital Medical School in London and Ipswich in Essex. Here the range of statutory domiciliary services is supplemented by "good neighbours". These are paid, local people, willing to give whatever is necessary, as additional support. The extra help needed is assessed by the key coordinators at practitioner level. The assessment for their medical needs and basic statutory home support is made by the statutory services, i.e. medical and social work specialists from the psycho-geriatric (psychiatric) and Social Services teams.

The statutory care that is supplementary to this includes the whole range of community nursing, social work and paramedical support available. However, such services leave many hours in every twenty-four totally uncovered when the old person may be at risk, alone, unhappy and unsupported, and it is here that the service is of great value. The additional local neighborhood carers give help ranging from simple reminders to take necessary pills to the whole range of personal care, toileting, feeding, putting to bed, etc., etc. The preliminary findings suggest that the cost is similar to that of institutional care, that it works for those who can get through the night alone and that it greatly improves the quality of life and may postpone hospitalization almost, if not until, death. Results also show that an earlier and open referral system might be more effective because it would pick up people *before* they reach the stage of heavy dependency on this type of system. This might ensure that they can be kept at home for much longer. We are also attempting to measure the limits of keeping people at home, not taking for granted that this is always the best way to care for people suffering from mental infirmity. It does ensure, however, that those who do go into institutional care go because of deteriorating health problems, not following a crisis in their care because their carers cannot cope any longer or because of an avoidable accident.

A London Borough (local authority) found similar results in measuring the satisfaction of elderly people and the staff caring for them in switching funds previously designated to provide residential institutions to providing a range of intensive home support services. Domiciliary welfare assistants working for the local authority supplement the other services and it has been found that the costs were lower than institutional care and the satisfaction levels higher. (Paper submitted Age Concern—Evaluation of social care—Kingston).

Another approach illustrated comes from Denmark. A recent innovation there consists of a 24-hour mobile nursing home service. This is an alternative, not an addition, to nursing home care. It is linked to a sophisticated alarm system through which emergency nurses, fully equipped, are guaranteed to arrive ten minutes after receiving a call for help. Otherwise they call regularly at prearranged times of the day. The savings have been found to be considerable when measured against alternative nursing home care and the satisfaction levels are high. The costs of the trials have shown that the annual costs of the twenty-four hour service are 110,500 Danish krona for maximum care. Medical ward hospitalization costs 940 Danish krona a day. It has also been shown that the decline in numbers going into nursing homes has been approximately one-half of those previously admitted. There is also a decline in bed use in hospitals forecast as a result of further introduction of this type of scheme. Again, direct savings in costs have been demonstrated, together with increased satisfaction. (Details available from Ensomme Gamles Vaern, Tingkif.evej 2, 2900 Hellerup, Denmark).

My third pair of examples consist of interesting attempts to blur the boundary between an institution and the local community it serves and of which it should be an integral part.

In Paris a voluntary society purchased a large apartment overlooking the Seine where old people discharged from hospital can live with their spouses for five or six weeks to become reaccustomed to living in a domestic setting. This is invaluable after debilitating treatment, surgery, etc. The use of social care/residential institutions as halfway houses in this way might be encouraged. Another form of care widely used in the United Kingdom is the day hospital. This is a part of the public hospital system but it is used for day care for very frail people requiring rehabilitation and treatment. It can avoid institutionalization and provide respite care enabling very frail people to stay in the community. One such day hospital in Hackney, London, a poor area of the city, has a night-time shelter and care facility available to day patients when the need arises for respite or if the old person needs a rest. It is financed by the Health Authority.

One voluntary Age Concern home in Norfolk has converted a previous traditional residential home for approximately thirty-five people into a short-stay home for between eight and nine hundred people a year. It has been found, however, that it is not advisable to mix short-term respite care residents with long-term residents, as the philosophy of care is very different for the two groups. (Reference study by Isobel Allen, Policy Studies Institute, London NW1.)

Could I now, in ending, recommend for your consideration two particular points:

1. Recent legislation being prepared in the Netherlands will mean that new applicants for a licence to run a nursing home/residential home will be obliged to offer facilities to the wider community in order to qualify. This will help to break down the barriers which exist between institutions and the wider community. It may be that the American system could consider something along these lines and lead the way to institutions becoming resource centers for local people who would be able to take meals, join in activities, hold meetings and generally bring life to and draw from the resources of the people who live in such homes.

Secondly, may I suggest that you give consideration to the need in each country for more preventive care. I believe the current criteria for your waiver limit the introduction of domiciliary services to people who would otherwise have to go into nursing home care immediately.

There are many ways of encouraging pre-crisis intervention as an explicit policy of continuing care, and the above examples and many similar schemes might prove to be both humane and cost effective in the long term and, if brought in soon enough, can avoid future expensive hospitalization and institutional living. Above all, they might offer a range of additional methods of serving the expressed needs and interests of the growing numbers of very old people among whom we may be fortunate enough one day to number ourselves.

Mr. Biaggi. I'd like to acknowledge the presence of another member of this committee, a gentlelady from Maryland, Ms. Helen Bentley. Dr. Franz Baro.

STATEMENT OF DR. FRANZ BARO, DIRECTOR, UNIVERSITY PSYCHIATRIC CENTER, CATHOLIC UNIVERSITY, LEUVEN, BELGIUM

Mr. Baro. Thank you Mr. Chairman, and members of the committee. I am a Belgium citizen, professor of mental health at the Catholic University of Leuven in Belgium, and director of a World Health Organization cooperating center for health, psycho-social and psycho-biological factors.

It is an honor for me to be invited at this hearing. You asked me to review mental health services and policies in European countries and to prepare recommendations to enhance long term care facilities serving mentally ill elderly.

In Europe, for sure, there are considerable variations within and between countries, regions and communities in response to the mental health problems of the elderly, but generally speaking, three principles dominate the national policies in this respect.

First, the elderly should be cared for in their own living arrangements as long as possible.

Second, if necessary, means must be found to care for them.

Third, optimum cooperation should be developed among all services.

Closer examination of European policies and programs in long term mental health care for the elderly reveals four general trends.

The first trend is that, the national policy places a priority on care within the local community, especially in the home rather than in the hospital or mental institutions. These policies call for early assessment and treatment that is community based and family focused, and closely linked family care with psychiatric and social services.

Excellent examples of this approach can be found in several cities in Bulgaria, Switzerland and the United Kingdom. Linked to this there are often excellent local examples of self-care and pay-care programs. For instance, the movement of people solidarity in Eastern Germany. More details will be given in a written statement about these examples.

The second general trend is that there is agreement that there are two few psychiatrists and other caregivers specializing in work with the elderly. It is widely recognized that because the primary care doctor, the so-called family doctor, is providing health care to the elderly in the community, a close cooperation between psychiatrists and that general practitioner, as well as other mental health professionals is essential.

Once more, an excellent example can be found in Knottingham in the United Kingdom, at the University Department of Health Care for the Elderly.

A third general trend is that there is agreement that mental health policies must include comprehensive services as a whole. This implies that mental health should be the responsibility of all health care providers, and that a wide range of services should be available, including preventive care, restorative care, family care and other alternatives. Good examples in this respect are found in the Netherlands and Belgium, where in fact there is a long tradition of provision of care for the elderly through old people's homes. An outstanding example of a mixed old people home and nursing home is given in Lacersinada in Belgium.

One has to consider in this respect, the services provided in the so-called spa health resorts. Excellent examples are available in Yugoslavia and they are used by Scandinavian countries. Taking this into account, the immense industry involved in the United States, the tourism of the elderly, also has to be reconsidered.

The fourth general trend is that the provision of appropriate, desirable, and needed levels of mental health services for the elderly is often constrained by periods of adverse economic conditions, yet there is ample evidence of local and regional alternatives for Mental Health Programs which often involve reallocation of resources and often present new innovations and improved services to the elderly.

For sure this economic situation often results, in Europe, in cutting back mental health services for the elderly and this is always the case in countries where mental health services have not the benefit of clearly articulated national policies. Without a clear identity and a clear national policy, the mental health service for the elderly tend to develop in a disastrous manner.

As I said already, the political option most often discussed is reallocation of funds to serve the needs of the elderly.

The second option includes changes in the use of services, such as a decrease in the use of hospitalization.

A third option is to increase the fiscal responsibility at the local community level, thus placing increased workload and responsibility on the family and the local voluntary sector.

A fourth option is improving the administration and organization of services.

Most, if not all health programs in Europe involve a mix of funding sources such as public governmental resources, public and private inference, individual payments and contribution of voluntary organizations. Thus, any reduction in the participation of any of these groups has negative consequences for care. Particular concerns in many countries appear to be related to three problems. The first problem being the definition of hospital beds and care, and the guidelines for reimbursement. The second problem relates to the interference of these guidelines for reimbursement with the location of elderly patients in the most appropriate care setting. The third problem centers around the use of public funds to support family members in the home care of the elderly.

For many elderly people, especially at the poverty level the financing of mental health services is closely related to resources provided through the social welfare system. While the welfare systems differ widely in many respects, the resources provided to the elderly clearly form the substantial part of the total expenditures related to mental health care.

As a general conclusion, community based mental health services for the elderly seem to be more successful in European countries or regions when they are supported by three components. First, by the benefits of a strong welfare system. Second, by the community care services of local, voluntary organizations. Third, by the financial resources provided by the elderly and their family.

Some examples will be given in the written statement. Thank you Mr. Chairman.

Mr. BIAGGI. Thank you. I'd like to point out before I invite the next witness to testify, that Dr. Butler's had a most distinguished career and his greatest distinction is the work he did at the National Institute of the Aging. Under his leadership, he had the unique distinction of getting more money each year, which is incredible, but as a result of it he really caused that institution to emerge and become a vital part of our Government's important research on behalf of aging. His landmark book, "Why Survive," has been hailed throughout our Nation. I can't speak sufficiently about Dr. Butler, but those of us in this area of activity know full well his committment and his profound contribution. Dr. Butler.

STATEMENT OF ROBERT N. BUTLER, M.D., BROOKDALE PROFESSOR; AND CHAIRMAN, GERALD & MAY ELLEN RITTER DEPARTMENT OF GERIATRICS AND ADULT DEVELOPMENT, MOUNT SINAI MEDICAL CENTER, NEW YORK CITY

Dr. BUTLER. Thank you very much, Mr. Chairman. I am very pleased to submit my testimony for the record and to highlight a few points.

Mr. BIAGGI. Certainly.

Dr. BUTLER. I am most anxious that our Nation not make some of the same errors it had made, in my judgment, in creating Medicare when we come to long-term care policy. I would like to be certain that we don't fail to provide adequately for training and for service and not simply identify financing as the key issue.

We have already heard Ms. Haven stress the importance of training, as also a cost effective way in Canada. In the United Kingdom and Scandinavia training in geriatrics, in medicine and nursing has expanded far beyond that in the United States, but we have an opportunity to change.

The use of Medicare money to support graduate medical education is under challenge. This challenge provides us an opportunity to innovate. Medicare now contributes $2 billion a year and by 1987 it is expected to be about $3 billion a year for graduate medical education, and yet, ironically or paradoxically, that money has never been used to support graduate medical education in geriatrics. even though the beneficiaries of Medicare are clearly and usually, geriatric patients.

We know too that we have a decisive shortage of well trained people in geriatric medicine and nursing, and that the needs that have been projected, for example, by the Rand Corp., are in the range of 10,000 physicians in geriatrics by the year 1990, a goal that is simply not going to be met. I propose in my extended testimony, which I will not repeat here because it will be part of the record, a modest proposal. A redirection of already existing Medicare funds in the range of about $100 million a year to finally reach the goal of at least 10,000 physicians well trained in geriatrics.

There are going to be 525,000 physicians in the United States by the year 1990, so 10,000 physicians in geriatrics is really a very small number. There are 7,000 skilled nursing facilities, for example, that should have medical directors. There are 127 medical schools that should have organized centers of excellence so that we can be absolutely certain that no one, no one graduate from medical school without proper training in pharmacology, how medications work in the aging body, in the differential diagnosis of Alzheimer's Disease, in the prevention of osteoporosis, in an understanding of the impact of bereavement on the body and mind. In short, the heart and substance of what geriatrics must be. The details of the proposal are contained within my testimony.

I'd like then to move on to the aspects of service delivery itself. Other nations have established exemplary programs, providing home care, day hospitals, respite services, and other components to insure decent long term care beyond institutions. It's painful to imagine that a Danish citizen holds on as a security blanket to her citizenship because she can't feel sure that in our country she is going to receive, for her family, dignified and decent care.

I think Canada should be especially highlighted and I'm very pleased that you have the report from the Kanes as part of the record, because it's a nation that has many of the same cultural and economic policies as we do, and therefore the usual argument that it's not transferrable from some other country to this one doesn't carry quite the same weight.

Some years ago when giving the keynote address before the American Public Health Association in Montreal, Canada I urged the creation of a major blue ribbon commission to deal with long term care. I did so knowing very well that there is often not much enthusiasm for blue ribbon committees and commissions, but frankly, I've sat on so many committees for the last 30 years that have related to long-term care, including task forces in the Carter administration and the Reagan administration and there have been marvelous option papers and economic analyses, and nothing ever happens. I think we can continue to have such excellent analyses, but I submit that we need an action oriented, high powered group of disinterested individuals. I am using that word disinterested the way it was used in the last century, to mean not with petty biases but with a broad national concern. I have in mind outstanding American citizens, not physicians, not members of the nursing home industry, not providers, but outstanding citizens to make decisions to help direct this country into some action with regard to long term care; and I suspect that type of long term care, financially will have to be supported in part by Government and in part by the private sector in some type of an important, dynamic sharing.

In that connection it gives me some pleasure to announce two new initiatives by foundations. I have been asked to be the chairperson of two advisory committees. One for a living at home program, which will be a $6 million effort spearheaded by the Commonwealth Fund, the Arthur Vining Davis Foundation, the Duke Endowment, the John A. Hartford Foundation, the Pew Memorial Trust, the New York Community Trust, and the Cleveland Foundation. I mention their names because it is exciting to see foundations work jointly in this way and it's remarkable that they're going to put $6 million up front in trying to develop innovative efforts to provide techniques and means by which people can remain in their own homes. It's important that we have that type of public-private movement together, as I think Andrew Stein emphasized as a very necessary step.

The second advisory committee or program, this one alone from the Commonwealth Fund, will focus upon those who are living alone. Now, not all persons who are living alone are in trouble, but a very high percentage are. They are usually women, because women so dramatically outlive men. We will also focus upon minority groups, and that group that has been emphasized this morning, 75 plus and 85 plus, the fastest growing age groups who frequently are among those that are most frail. We wish to concentrate in this roughly $5 million program in further developing innovations that will help provide services directly to that group that has been left very much behind in the wake of the other more dramatic and effective efforts for those that do have a partner, that do live together and that do have, happily, the support of Medicare and Social Security.

Third and last, I must of course, stress the importance of research. We don't devote any part of Medicare funds for R&D. We have stressed, you have stressed, you are distinguished in your contributions of trying to provide support for the Alzheimer's families. But the ultimate cost containment and the ultimate service is to solve Alzheimer's disease. After all, in 1935 we had the beginnings of the March of Dimes; by 1961, we had the last epidemic of polio. Less than 30 years. While I don't think any selfrespecting, responsible scientist would automatically claim that we can do the same for Alzheimer's disease in some specific timeframe, we are certainly not going to solve it if we don't provide adequate funds for the number four disease. At most we are spending about $43 million a year which, frankly, is a drop in the bucket given the $10 billion-plus that is being spent just in nursing home care, let alone other care for people that are suffering from this devastating disease, devastating to families.

The National Institute on Aging still only receives 2 percent of the entire NIH budget. Two percent, .even though rising health costs relate to aging, as you very well know and I hardly need to repeat. The other NIH institutes also happily focus upon many of the problems of age. But we are beginning to enter a new era. We are coming to the realization that we can begin to understand the fundamental bioligical mechanisms of aging, and that, through that understanding, we can find ways to deal with many of the deleterious effects, bone thinning, or osteoporosis that leads to the hip fractures that accounts for $2 billion of costs in every year, Alzheimer's Disease and many other conditions which we don't have time to discuss. With age comes a greater vulnerability to disease and along with environment, lifestyle and genetics it's aging that constitutes the great class of antecedents to disease. Yet only 2 percent of the NIH budget is devoted to the National Institute on Aging. Practically nothing is devoted to creating outstanding leaders in geriatrics. There are about 100 medical fellowships in geriatrics in the entire United States. I have 12 of them in my own small program at Mount Sinai, so it's illustrative of how far we have to go.

I would close by summarizing the importance of our developing comprehensive care that does not leave out social work, nursing, the variety of other disciplines and services that really make humane and decent care possible. While I have, understandably, emphasized the medical and the research perspective, the committment to the utilization of the entire team in the assessment, promotion, and maintenance of function is absolutely critical to long-term care. Even in the United Kingdom there have been difficulties in managing the relationship between social services and medical services, so we have to try to integrate them in the very beginnings as we move toward the adoption of an effective long-term care policy, I am sure that Congress will do so in the very near future.

Thank you.

[The prepared statement of Dr. Butler follows:]

PREPARED STATEMENT OF ROBERT N. BUTLER, M.D. BROOKDALE PROFESSOR, AND CHAIRMAN, GERALD & MAY ELLEN RITTER DEPARTMENT OF GERIATRICS AND ADULT DEVELOPMENT, MOUNT SINAI MEDICAL CENTER, NEW YORK CITY

I am pleased to testify before the U.S. House of Representatives Select Committee on Aging concerning this most important and critical topic, long-term care, specifically in comparison to other nations. You asked of me "how the current system can be improved and what lessons may be learned from other countries."

I am most anxious that our nation does not make the same errors in long-term care that it made in the creation of Medicare which over-emphasized financing issues. They are, of course, important, but should not overshadow needed reforms in education and service delivery. We need health policy, not just health insurance policy. Let's not make those mistakes again as we move to provide appropriate and affordable long-term care in this country.

TRAINING IN GERIATRICS

In the United Kingdom and Scandanavia training in geriatrics (medicine, nursing, etc.), has expanded far beyond efforts in the United States.

But we have an opportunity to change. The use of Medicare money to support graduate medical education is under challenge. This challenge is an opportunity to innovate.

Whatever conclusions are reached about this general issue, I believe there is a valid, specific role for Medicare to support the training of physicians in geriatric care. Let me explain why.

Medicare now contributes $2 billion a year toward medical education in general. This contribution, paradoxically, has not led, in any substantial way, to the training of physicians expert in geriatric care.

The American health-care system today is poorly geared to the needs of the elderly. Medicare is basically an acute-care insurance system; it is unable to support chronic care. In this respect, Medicare shares the misalignment of the entire system.

Even if our country were to take public and private steps to insure coverage of chronic care tomorrow, a shortage of well-qualified physicians in geriatric care would undermine that effort and any other initiative to improve care of the elderly.

Modest steps can be taken now to help remedy that shortage and prepare for the further alignment of the system with needs of the growing Medicare population.

Despite all the talk about a physician surplus, with a total of 575,000 U.S. doctors expected by 1990, there is no doubt about a continuing deficit in geriatrically oriented physicians. The Rand Report (1980) provided an estimate of need for 1990 and later. The Report concluded that adequate medical care of those aged 75 and over would require, by 1990, 7,000 to 10,3000 physicians well-qualified in geriatrics.

This level will not be achieved at the current pace of medical education in geriatrics, largely because training programs are scarce. Our department is the only department of geriatrics in any U.S. medical school. It is not necessary that other schools establish geriatrics departments. But is is essential that they initiate geriatric training as part of the basic medical curriculum.

We can make up somewhat for lost time with a relatively modest expenditure if undertaken quickly.

The proposal below does not contemplate placing new dollars into graduate medical schools from the Medicare system. Rather, it would *redirect* a modest portion of current spending to meet an urgent, critical need. The costs of the training I propose would be 3 percent of the $2 billion Medicare contribution to current medical education.

Here is my proposal:

1. Support training of 2,000 geriatric fellows per year in two-year programs. Over a decade (five cycles), this would mean training 10,000 physicians proficient in geriatric care. (Our department has 14 fellows in training.)
2. The Nation has 127 medical schools. The goal of 2,000 fellows per cycle could be reached if each school would develop a sound program to train 16 fellows. A two-year fellowship in geriatrics would follow completion of residency training, for ex-

ample, in such primary-care fields as internal medicine, family practice and psychiatry. Since no single medical school department could normally be expected to absorb 16 fellows, they probably could be distributed among several departments if the medical school provided coordination by a geriatrics program chief reporting to the dean.

3. The estimated average annual cost of training one fellow is $35,000 for salary and fringes. (This national average will vary according to local training and other costs. The total for training 2,000 wold be $70 million per year.

4. To prepare and administer training programs, including faculty development, Medicare would make funds available at each medical school that meets criteria for developing geriatric services and personnel. The funds could be generated under conventional arrangements for Medicare payment of services, or another option consistent with Medicare objectives.

5. The arrangement should generate at least $250,000 per school annually, for establishing and operating training programs including faculty development provided the criteria are met. If all schools participated, the annual expenditure would be $30 million. Although it would be ideal to have all 127 U.S. medical schools participate, the program could be set up as a competition to identify the 50 or 60 with the most responsive plans. Criteria for selecting the schools could cover arrangements for a teaching nursing home, a mandatory clerkship in geriatrics for undergraduates, and integration of geriatrics into the first two years of medical school. (The criteria might include a requirement that a school must raise $1 in nonfederal money for each $1 in Medicare money, thus producing $500,000 for annual activities in training and faculty development.)

6. Over a 10-year period, the Medicare cost of the proposed program, including fellowship support and faculty development, if all medical schools participated, would average out to $100 million per year.

Such expenses, are appropriately Medicare expenses, inasmuch as the physicians would be trained to provide effective and efficient care of precisely the population Medicare covers.

7. The suggested program could be self limiting. In time, as graduate medical education responds under the program's influence, the program could be absorbed into the mainstream and phased out or it could become a regular but limited effort to assure that a basic output of physicians trained in geriatrics.

8. To coordinate this effort, the lead agency should be the National Institute on Aging with cooperation of Administration on Aging, Health Resources and Services Administration, and Veterans Administration.

In my view, the general costs of medical education should be carried by the whole U.S. population through general revenues. Allocations to medical schools may properly be based on agreements based on meeting national needs.

THE NEED TO PUSH THIS COUNTRY ON LONG-TERM CARE

Other nations have established exemplary programs providing home care, day hospitals, respite services and other elements to assure decent long-term care—beyond institutions. Canada should be especially highlighted because of its similar cultural economic and political perspectives. I would especially recommend a careful reading of the recent report on Canada by the Kanes.

In the keynote address for the 1982 Montreal meeting of the American Public Health Association, I called for the formation of a blue-ribbon, private-sector commission on longer-term care insurance.

Given the reluctance of private insurers to move quickly and boldly and the aversion to expanding public insurance (Medicare), I believed that vision and leadership were needed to break the impasse. For example, the Hall commission in Canada played a critical role in the 1960s in the evolution of national health policy. Could some similar vehicle be useful in the American context for resolving impediments to the development of long-term care services?

I thought a blue-ribbon panel of lay leaders, with expert staff, could conduct hearings to define the problems and educate themselves and the public, and prepare the technical studies and option papers. The spectrum would cover finance, organization of services, personnel development, coordination of formal and informal supports, administration, and governance (representation of payers and consumers).

Going further, the Commission would seek consensuses for action, and prepare a report and recommendations. These were not to be left to gather dust on a shelf. The panel would stay in existence to receive public criticism of the report and recommendations. It would refine them and then advocate a course of action involving public and private sectors.

I searched for foundation support for the commission, including its technical studies. Ronald Pollack of The Villers Foundation tried a convenor role with several foundations. James Firman, then of Robert Wood Johnson Foundation, was attracted to the cause. He elicited interest among several foundations. But some were apparently not comfortable about funding anything more than an analytical effort, though they did believe that this could be helpful to any commission that might arise. The consensus was for supporting a "CBO-type" of study, as Firman put it. And that is my understanding of the pre-history of the Brookings Institution study, directed by Alice Rivlin.

The recent paper by Kane and Kane on Canada dramatically illustrates how effectively the great nation to our North with a similar culture has been able to provide long-term care.

There are signs of innovations in service. The group of foundations—the Commonwealth Fund, the Arthur Vining Davis Foundation, the Duke Endowment John A. Hartford Foundation, the Pew Memorial Trust, the New York Community Trust and the Cleveland Foundation—have established the Living-At-Home program to stimulate projects in American cities.

3. RESEARCH

The ultimate tool of cost containment in services and the conservation of life is research. We cannot wait until the Baby Boom generation reaches 65 before we invest in aging research particularly to prevent and/or treat such devastating diseases—long-neglected—as Alzheimer's disease and osteoporosis.

I was most please that Congressman Roybal recently called for 10 new Alzheimer's Disease Research Centers. This was part of Congressman Roybal's recent proposed legislation to provide research, training and services related to Alzheimer's disease.

As the first Director of the National Institute on Aging and now the head of the nation's first Department of Geriatrics and Adult Development at Mount Sinai School of Medicine, I have a unique perspective of the impact the NIA has had on the growth of aging research within the United States. Since 1975, when it began with a total budget of less than $16 million, it has become an important influence on much of the aging research and research training being carried out within the universities and research institutions of the country. It has called attention to the diseases and conditions of older life which negatively impact upon the lifestyles and the quality of life of these individuals. Through its research programs, it has provided recognition that many of these health problems which previously had been considered a consequence of growing old are, in reality, disease states which have a potential for treatment and cure. And, finally, it has promoted the idea that any improvement in the quality of life not only directly benefits the elderly individual but also reduces the health care costs of our elderly population.

Although the overall budget for the NIA has increased over the last ten years, still a relatively small amount is being invested in this area of research, particularly when related to the costs of health care attributable to our over-65 population. These health care costs are estimated to be about $110 billion. The FY 1985 budget at the appropriations level of $144 million amounts to just one-tenth of one percent of these costs. Surely the United States can afford a larger contribution to this effort which will potentially lead to not only an improvement in the health status of these individuals but also to a reduction in their rapidly-increasing health care costs, a portion of which is covered through medicare.

There is so much that needs to be done. Only about 2% of the entire NIH budget goes to the newest of the National Institutes of health-one so important because of the burden of illness and health costs related to aging. The National Institute on Aging needs a major infusion of funds and personnel to implement the intent of Congress which created the institute.

Final Thoughts: In our country and perhaps other countries as well chronic and acute care have unfortunately become separated. The reintegration of chronic and acute care is quintessential and can only come about through the adoption of effective policies for training in clinical and research geriatrics and the provision of financing mechanisms such as social insurance (private or public or both) for long-term care. This also requires coordination of health and social services. Unfortunately, Medicare helped to split them in this country because its focus was so heavily on health insurance rather than health policy.

Of course, what is really needed is a comprehensive national health policy for all ages. Human beings cannot be divided up into bits and pieces but we must have a vision of the total life course.

One must not over emphasize "insurance" at the expense of "health" issues. Our society's policies have been over balanced towards what works as an insurance and the perspective of what works from the insurance perspective. This is not been the case in Canada.

Population is the single great important national resource. Japan which does not have rich material and energy resources in its limited island space with a size less than our state of Montana has demonstrated the extraordinary importance of its population, of its human resource, its people. Ultimately, people improve an economy—the standard of living and build a better quality of life for all ages. This must be translated into programs of health maintenance and disease prevention of and of support for research toward understanding human performance and how it changes with time. We must also create designed environments that facilitate "productive aging".

In other words, we must do more than emphasize the need to create innovations in long-term care. We must emphasize how to promote the productive capabilities of older persons in all societies. This is a much more positive policy, an enlightened and optimistic approach—rather than allowing people to unnecessarily slide into awesome social and terrifying personal dependency.

The DRGs are a methodilogical triumph of sorts and a service delivery disaster for older people and the poor. They do not take into account the multiplicity complexity and severity of illness seen in poor people.

Mr. BIAGGI. I can't help but comment when you make reference to 2 percent. It also brings to mind the whole picture of the aging. I think one of the problems is competition for the dollars, severe competition for the dollars and there are people out there who have established beachheads for the nursing and the home industry is currently established, they were there long before this movement, this focus, this shift is commencing. Even home care, whether it be Meals on Wheels, you find ourselves just getting a mere pittance, and only because we're working all the time. It isn't that there isn't incentive and support, you know that. It's a question of you fighting the firmly entrenched institutions who already have established their umbilical relationship with the Government and that the funds are already committed in a sense, and——

Dr. BUTLER. That's one of the reasons I especially emphasized the opportunity that now exists within Medicare. As you know, the administration, just a matter of 2 weeks ago, reduced the funding for graduate medical education. So, here is an opportunity, without offending the other medical disciplines, the turf that is already established, the umbilical cord that you emphasize. We could now redirect modest amount of money because out of $3 billion of Medicare by 1987 to have $100 million of it targeted specifically to the development of faculty within medical schools to teach geriatrics and to create national fellowship programs, would be very modest. It would be politically opportune; it would be economically sound, and I think the country and the families of this country, absolutely need it.

Mr. BIAGGI. No question, given the burgeoning nature of the problem, it's going to develop in extraordinary fashion. I just have to make one comment. You made reference to it and I've been just waiting to get to it. Ms. Codel's comment about maintaining a Danish citizenship because she needs that security blanket. Well, it certainly indicates that we should review what we are doing here. I won't go so far as to say it's an indictment of our system, but something is radically wrong and it should be reviewed. Now, whether that's the condition they should mind or whether it's parochial or regional should be assessed, but that's totally unacceptable and your testimony, if that's all you said, was enough for all of us to be alerted.

Dr. BUTLER. Maybe we should have one of the baby boomers up here, because if the baby boomers aren't prepared by the time they reach golden pond, they're going to fall into that pond.

Mr. BIAGGI. There may not be any water. The next witness, Dr. Rivlin. We are honored to have you Doctor, because as former Director of Congressional Budget Office we are fully cognizant of the high regard in which you have been held and your leadership in developing the certain issues and policy guidances for our nation, and we are just delighted to have you.

STATEMENT OF DR. ALICE M. RIVLIN, DIRECTOR OF ECONOMIC STUDIES, THE BROOKINGS INSTITUTION

Dr. RIVLIN. Thank you, Mr. Chairman, I am very pleased to be here with my colleague Joshua Wiener. The two of us are directing a study at the Brookings Institution that will look at alternatives for long-term care, both for delivery and for financing. We are happy to have Dr. Butler as one of our advisers.

I am delighted that you are having this hearing and considering what can be learned from the experience of other countries that will help us devise a better system for the elderly. Clearly, continuing care for the elderly is a concern of all advanced countries. They are facing high and rising percentages of the elderly people in their populations. Improvements in medical technology and knowledge have cut mortality rates, fertility has been falling at the same time. In the United States, as Senator Pepper said earlier, the percentage of people ove 65 can be confidently expected to rise from around 11 percent to nearly twice that, about 21 percent by 2040.

Many countries have had that rise in part already. Sixteen percent of the population in Sweden in 1980 was already over 65. We can learn from them as they cope with these higher percentages, what is in store for us.

All countries are also facing escalating costs of medical care attributable to rapid advances in technology, and they are facing the difficult problem, which none have found easy, of developing strong incentives to hold down costs without reducing the quality of care.

Nobody has all the answers. All the systems are complicated by long histories and suffer from certain weaknesses. All have made tradeoffs in different ways in different places. We are conscious, as many have said this morning, that our system has its own weaknesses, and we need to learn about how other countries have solved problems.

Let me mention three main weaknesses. One is a bias toward institutionalization: The concern that elderly people end up in nursing homes that could be cared for more effectively, more humanely, and at home with less cost.

Another is that our public financing system, especially Medicaid, is degrading, because it requires people to spend down their assets in order to qualify for publicly supported care.

Finally, there is the concern that high and rising expenses, both for medical care and for long term care, are going to get us in trouble. As the proportion of the elderly rises, the cost will become a heavier burden. We have to look at the ways in which other countries have dealt with these rising costs to see what their successes have been.

The institutional bias is a frequent allegation. Public funds are more available for institutional care, especially for nursing home care under Medicaid, than they are for home care. Until recently indeed, almost nothing was available from public sources for formal support services for those caring for the elderly in their own homes. The question of how to provide home care services has been dealt with in a variety of ways in European countries. Home care cases in relation to the elderly population are much higher in Sweden, in the Netherlands and in the United Kingdom, although they are lower in Canada.

The proportion of home helpers is much higher also in Sweden, in the Netherlands, and in the United Kingdom. You have heard some about that system this morning. One wonders, of course, whether the success in providing home care accounts for the relatively low proportion of the elderly who are in institutions in the United Kingdon, in Sweden and in the Netherlands. It's probably relevant, but it is not the main motive for providing home care. It is partly tradition and the feeling that it is more appropriate for older people to remain at home.

Also, as has been mentioned this morning, the imaginative use of congregate housing in many of these countries, and especially in the Netherlands, is another approach to keeping people in satisfactory facilities other than nursing homes.

The lesson is clear. We in the United States must look in detail for successful models of home care and for other specific housing arrangements and there are plenty of places to look.

Second, there is the question of pauperization, as it has been called. In the United States, Medicare covers hospitals, but very little nursing home care. There is little private insurance to cover nursing home care. There is, in general, a reliance on Medicaid. Middle-income people who need nursing home care must spend down their assets to become eligible. Medicaid now pays an astonishing half of the nursing home costs in the United States. This was not intended when a program for the very poor was passed, and it is probably not desirable.

We need to examine other systems. We need to examine ways of encouraging private insurance to take over a part of this burden, and to find a way of covering nursing home costs more generously under other public programs that do not require pauperization.

It is certainly possible, and many other countries do this, to have fees which are tied to income or copayments which are tied to income, without making the whole burden fall on a program designed for the very poor.

Then there is the problem of the rising costs. This is clearly a problem everywhere. In the United States for two decades medical costs have been rising very much faster than other prices. We now spend nearly 10 percent of our gross national product for health care. The combination of third-party payment of many of these costs and the rapid technological advance has done this to us. We are now looking for ways to hold down public costs in the face of the deficit in the Federal budget.

Other countries are dealing with this in a variety of ways and we need to examine these. First, there are constraints on the supply of services. That's easier in a country where you have a national health service. The United Kingdom, for instance, contains hospital and surgery costs by rationing them.

Second is screening and case management, which we have heard about from Dr. Havens and others today. Denmark, the Netherlands, and Japan make good use of screening to be sure that admission to an institution is for the severely impaired who do not have alternatives, and that other alternatives are found for those that can be cared for in less costly ways.

Another theme that we have heard this morning is prevention. There is great potential for the control of hypertension, and osteoporosis, for example. We need to work on diet and exercise as preventive measures to prolong health and vigor among the elderly. Sweden, Germany, France, and Denmark are all putting major emphasis on prevention.

Another way of holding down costs is to have part of the payment paid by the patient. Even where entitlement to services is very basic, as in Denmark and in the Netherlands, copayments are used in part to share the cost and to give the patient an incentive to economize on health and long-term care resources.

But, no matter where we end up, we must recognize that more resources, public or private, will be required as the proportion of the elderly rises rapidly in the next century. The United States has tended to rely on the private sector very heavily, although less so for the elderly than for general health costs of the rest of the population. Medical care for the elderly is now about two-thirds public and about one-third private. But long term care is much more heavily out of pocket and privately paid for. Public expenditure cover less than half the cost of long-term care.

In Europe in general there has been much more reliance on the public sector for the care of the elderly, including long-term care. The result is that a higher proportion of their national product goes for care of the elderly. As the proportion of the elderly rises the United States must be prepared for a higher bill. We can work at ways of having private involvement and responsibility increase. Long-term care insurance is now almost unavailable from the private sector, but there is no reason to think that it might not be in the future, if the insurance companies are encouraged. We need to work on intermediate housing, on affordable life care communities, and on ways of using the elderly's equity in their own housing as a means of financing care.

The alternative, of course, is higher taxes to support greater public provision. In the end, I suspect it will be a mix of both. This is probably both inevitable and desirable. But we need to think hard how to do it and look for models all around the world.

Thank you.

[The jointly prepared statement of Alice M. Rivlin and Joshua M. Wiener follow:]

PREPARED STATEMENT OF ALICE M. RIVLIN AND JOSHUA M. WIENER, THE BROOKINGS INSTITUTION, WASHINGTON, DC

We are delighted to meet with the Committee as you consider what can be learned from the experience of other countries that might improve the continuing care available to elderly people in the United States. At the Brookings Institution, we are beginning a study of the organizational and financing options for long term care of the frail elderly in the United States. We have not made an intensive study of arrangements in other countries, but a preliminary survey of the variety of approaches in several industrial countries has persuaded us that the United States has much to learn from the experience of other nations in dealing with the challenge of providing high quality care for elderly people at reasonable cost.

All advanced industrial countries can anticipate a rapidly growing elderly population resulting from declining mortality rates combined with a relatively smaller working population resulting from lower fertility rates. How to organize the long term care delivery system and how to finance those services are, becoming therefore, increasingly important public policy issues worldwide.

As the United States addresses its own long term care problems, it is useful to examine the experiences of other countries for two reasons. First, most industrial countries have higher proportions of population age 65 and over than does the U.S. (Table 1) (United Nations, 1982). Thus, these countries may point the direction to which the U.S. is heading as its percentage of the population which is elderly increases from 12 percent in 1980 to an estimated 21 percent in 2040

In addition, dissatisfaction with the U.S. long term care system is widespread. Critics have argued that the U.S. system is flawed in at least three major ways: First, the delivery system is biased towards nursing home care, forcing some persons to be institutionalized who do not need to be. Second, the financing system is degrading because it forces people to impoverish themselves in order to qualify for government assistance. Third, the U.S. system is expensive and expenditures are increasing at an unacceptably high rate. Other countries may provide lessons, models and ideas from which the U.S. might learn.

This paper briefly reviews the organization and financing of long term care for the elderly in Western Europe, Canada and Japan with an eye towards implications for the United States. It takes as it basic framework the criticisms of the U.S. system that were just mentioned and examines the experiences of other countries to see what they can tell us about alternative approaches.

INSTITUTIONAL BIAS OF THE U.S. LTC SYSTEM

One frequently voiced concern about the U.S. system of care for the elderly is that it may be biased toward institutional care. Families caring for an elderly relative at home have little formal service support. Public funds are often available for nursing home care, but not for provision of care in the home by visiting nurses, health aides, or housekeepers. Hence it is argued that families tend to put an elderly patient in the nursing home when some supporting services would have enabled them to keep the patient at home at lower cost and to the patient's benefit.

Although a relatively small proportion of people over 65—about 5 percent—are in nursing homes now, the proportion is much higher for the very elderly, who are the most rapidly growing group in the U.S. population. Moreover, as increasing numbers of women enter the labor force, families may be much less able to care for elderly relatives at home than they have been in the past. Hence, attention has focused on home health care as a possible way of preventing expensive and undesirable increases in institutionalization in the future.

Some Western European countries offer a wider array of publicly-financed noninstitutional services than the U.S. For example, as shown on Table 2, the number of publicly financed home care cases per 1000 elderly in Sweden (260), the United Kingdom (291), and the Netherlands (233) are about double the number provided in the U.S. (U.S. Senate Special Committee on Aging, 1984) Similarly, Table 2 also shows the numbers of home helpers per 100,000 population in 1976 for those countries was far above the number in the U.S. (923 in Sweden, 265 in the United Kingdom, and 265 in the Netherlands vs. 29 in the U.S.) (Nusberg, 1984). On the other hand, home health care in Japan is in shorter supply than in the U.S. and Western Europe (Little, 1982). At least some of this impression that the United States is lagging far behind some European countries, however, comes from studies which do not take into account the phenomenal growth in U.S. Medicare home health expenditures and utilization during the last eight years.

Differences within Europe are substantial. The U.K., the Netherlands and the Scandinavian countries make accessible a broader spectrum of services than does

Germany or France (U.S. Senate Special Committee on Aging, 1984). France and Germany have a lower supply of home helpers than those countries, and have a much lower number of public home care cases per 1000 elderly population (Nusberg, 1984; U.S. Senate Special Committee on Aging, 1984).

Although the data are sparse and definitional and reporting problems make comparisons quite unreliable, work conducted by Wilensky et al. indicates that countries with more noninstitutional services and more group housing have lower nursing home utilization (U.S. Senate Special Committee on Aging, 1984). In particular, the percent of the elderly in nursing homes in Sweden (3.1 percent), the Netherlands (4.0 percent) and the United Kingdom (3.9 percent) are a good deal below that of the United States (5.3 percent). Compared to Western European countries, Japan provides very little in the way of formal institutional long term care services. Only 1.5 percent of the elderly are institutionalized in Japan. This is probably because almost 70 percent of the elderly live with their children (Campbell, 1984). Canada has a higher rate of institutionalization compared to other countries (7.1 percent), partially due to biases in the health insurance system which did not initially cover home care services (Schwenger and Gross, 1980).

Whether this inverse relationship between home care and institutionalization is the result of the substitution of home care and sheltered housing for nursing home care or the result of countries artificially constraining the supply of nursing home beds in unclear. Many countries report nursing homes shortages and some Western European countries are in the process of building more nursing homes (Meyer, 1984; U.S. Senate Special Committee on Aging, 1984). Moreover, use of acute care beds to care for chronic care patients appears to be much more common in Europe than in the United States.

For the most part, the issue of cost-effectiveness of noninstitutional versus institutional services which dominates the U.S. debate is absent from Europe and Canada. There is relatively little in the way of rigorous research on this topic. The provision of home care in these countries stems largely from a policy preference for those kinds of services (Kane and Kane, 1976).

Another approach to reducing the need for institutional care is the provision of housing for the elderly with some support services available. Sweden, the U.K. and the Netherlands, all have considerably more elderly in "group quarters" than in nursing homes, while the United States has only a tenth as many elderly in group quarters as in nursing homes. These intermediate housing arrangements may be even more important in explaining the low level of institutional care in these countries than the availability of home based services.

PAUPERIZATION AS A PRECONDITION OF GOVERNMENT SUPPORT

Another frequent criticism of the United States' system for providing long term care is that elderly people must impoverish themselves before they become eligible for publicly funded long term care. Contrary to widespread belief, Medicare provides only very limited long term care coverage. Government funding for nursing home services and noninstitutional long term care is principally through Medicaid, the social services block grant and state funds. These programs, with minor exceptions, are strongly means tested. Thus, elderly people who cannot afford the high cost of private care are forced to "spend down" their income and assets to very low levels in order to qualify for government assistance. Medicaid, a program originally designed to meet the needs of the poor, now pays approximately half of all nursing home costs in the United States.

In most of the countries reviewed, long term care services are largely publicly financed, although the extent of coverage differs for each type of service. Countries generally insure the entire population for nursing home and skilled home care, with no or little out-of-pocket payments required (Nusberg, 1984). On the other hand countries often have sliding fee scales for other forms of long term care, such as personal care or meal services. Despite the fee schedules, however, in the U.K. and Japan, the substantial majority of the elderly receive these services at no cost (Kamerman, 1976; Campbell, 1984).

RISING PRESENT AND FUTURE COST OF LONG-TERM CARE

Policy discussions about long term care in the United States have been increasingly dominated by concerns about how to hold down future costs. Medical care spending, in general, has risen extremely rapidly in the United States over the last two decades and now accounts for about 10 percent of the gross national product. Reasons for the rapid increases in spending on medical care include the increasing sophistication of medical technology and the spread of third party payment, which reduces the incentives of both patients and providers to hold down costs. Although long term care is much less frequently covered by insurance than acute hospital care, these expenditures have also been rising. Total nursing home expenditures (public and private) increased by 12 percent a year between 1980 and 1983. Medicaid long term expenditures for the elderly increased by 9 percent a year during this same period.

Especially with enormous budget deficits, Federal policy has been increasingly geared towards cost containment. Indeed, long term care policy in the U.S. has been paralyzed by fears of the exploding costs that might result from expanding noninstitutional services and by making nursing home coverage a nonmeans tested entitlement, as has been done in some European countries and Canada.

The countries reviewed utilize a wide array of mechanisms to control expenditures. Few of these mechanisms have been rigorously evaluated in the countries where they are used. Several of these approaches have been tried in the U.S., although usually on an experimental basis. These mechanisms include:

1. Placing constraints on the supply of nursing home beds and home care providers as a way of limiting total utilization of services. In a national health system as opposed to health insurance systems, direct control over health resources can be used to control costs.

This is most clearly the case in the United Kingdom (Aaron and Schwartz, 1984).

2. Pre-admission screening of potential nursing home patients is another form of cost control. Some countries use strict screening criteria which allow only those individuals who are severely impaired or who lack social support to enter institutions. This is practiced most extensively in Denmark, the Netherlands and Japan (U.S. Senate Special Committee on Aging; Campbell, 1983).

3. Prevention has been emphasized as a means of delaying institutionalization and, consequently, containing costs in several countries. Sweden, Germany, France and Denmark have all recently focused on primary care measures, such as exercise and traffic safety as a way of preventing more expensive acute care treatment (U.S. Senate Special Committee on Aging, 1984). In a similar manner, Japan has established a specific policy goal of disease prevention for the elderly. The 1982 Health and Medical Care Act for the Elderly introduced health promotion programs for those age 40 and over to be delivered at the community level, assisted by the regional level and financed jointly by the municipality, region and state (Cragen, 1985).

4. A final example of cost control is the introduction of co-payments for care. Denmark and the Netherlands both require a modest contribution toward nursing home care. In the Netherlands individuals are expected to contribute part of their pensions toward care after six months in a nursing home, and in Denmark nursing home residents with savings are required to contribute 60 percent of interest income toward their care (Nusberg, 1984). Japan also has recently required a co-payment for medical care and drugs in an effort to control costs (Nusberg, 1984; Cragen, 1985).

LONG-TERM CARE: WHO WILL PAY?

Currently, the U.S. relies on a mix of public and private financing of health care for the elderly. Altogether, public financing accounts for about 67 percent of total health care expenditures for the elderly, whereas private sources (out-of-pocket and private insurance) account for about 33 percent (Waldo and Lazenby, 1984). Long term care financing is much more dependent on out-of-pocket expenditures, with only 48 percent of nursing home care being financed directly by public programs.

In Europe and Canada the answer to the question "who will pay?" is the public sector, financed through taxes. Moreover, none of the countries analyzed significantly rely on the private financing ideas that have been suggested recently in the U.S. (e.g. private long term care insurance, reverse mortgages, life care communities, and individual retirement accounts for long term care).

Expenditure data show that as a percent of GNP, most European countries spend more government money on the elderly relative to the U.S. (Table 3). The range in Europe is from 7.7 percent of GNP in the United Kingdom to 14.5 percent in Sweden, compared to 5.9 percent in the U.S. and 5.4 percent in Canada (U.S. Senate Special Committee on Aging, 1984). Similarly, publicly financed health expenditures for the elderly are also relatively high—ranging from 1.6 percent to 2.8 percent of GNP in European countries compared to 1.1 percent in the U.S. and 1.2 percent in Canada. These data suggest that Western European countries spend more public money on the elderly, although private expenditures on the elderly are unknown.

Although public expenditure data indicate that the Europeans spend more on health care for the elderly, it is unknown how much of this is for long term care.

Given the greater public provision and funding of noninstitutional services and the lower personal contributions required in Western Europe, there is reason to believe that more public funds are spent on long term care for the elderly than in the U.S. Moreover, total expenditures for long term care—both public and private—are hard to compare since data on private expenditures on the elderly are not available for other countries. The Health Care Financing Administration is attempting to gather this information for the International Social Security Administration. Thus, total American expenditures may be just as high as the European systems, but private funds play a much larger role in the U.S.

Whether the public or the private sector pays for long term care, there is little doubt that the bill will be considerably larger in the future. Europe, Canada, Japan and the United States are all aging societies, facing large increases in the elderly population. Projection of current age specific utilization patterns in the U.S. suggest that there may be four times as many elderly in nursing homes in 2040 as there were in 1980. Somebody must reach into their pocket to pay that bill. For the U.S. it seems inevitable that both the private and public sectors will have to pay more for long term care.

The key questions are what should be the mix of nursing home and noninstitutional services, to what extent should public programs be means tested, and what should be the mix of private and public services and financing. Our test as a society will be whether we can organize the care and financing needed in a humane and reasonable fashion.

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TABLE 1.—PERCENT OF POPULATION 65+ AND PERCENT OF POPULATION 75+ FOR SELECTED COUNTRIES, 1980

	65+	75+
United Kingdom	14.9	5.5
Sweden	16.2	6.2
Denmark	134.3	5.5
The Netherlands	11.5	4.4

TABLE 1.—PERCENT OF POPULATION 65+ AND PERCENT OF POPULATION 75+ FOR SELECTED COUNTRIES, 1980—Continued

	65+	75+
France	13.7	5.6
West Germany	15.0	5.5
United States	10.7	3.9
Canada	8.9	3.1
Japan	8.9	3.0
Australia	9.3	3.2
New Zealand	9.2	3.2

Source: U.N., Demographic Indicators of Countries for 1980 (1982).

TABLE 2.—SELECTED UTILIZATION AND SUPPLY MEASURES

Country	Percent elderly in institutions	Percent elderly in group quarters	Public home care (No. cases per 1,000 elderly)	Home helpers (No. per 100,000 population)[1]
United Kingdom	3.9	5.4	291.4	265.0
Sweden	3.1	6.1	259.7	923.0
Denmark	5.3	.9	152.7	NA
The Netherlands	4.0	11.1	233.2	599.0
France	5.2	1.4	52.1	14.3
West Germany	3.6	.9	26.0	22.0
United States	5.3	.5	136.5	28.7
Canada	7.1	1.6	24.3	15.0
Japan	1.5	NA	NA	7.7
Australi	NA	NA	NA	NA
New Zealand	6.0	NA	NA	NA

[1] From Nusberg, 1984. Adapted from figures provided by the International Council of Homehelp Services, Feb. 1978. Data for 1976.

Sources: U.S. Senate Special Committee on Aging, 1984.

TABLE 3.—PUBLIC EXPENDITURES FOR THE ELDERLY FOR SELECTED COUNTRIES

Country	Total public expenditures for elderly		Publicly financed health care expenditures for elderly		
	Percent GNP	Percent GNP/percent elderly	Percent GNP	Percent GNP/percent elderly	Per capita expenditures
United Kingdom	7.7	0.52	1.7	.11	$ 975
Sweden	14.5	.90	NA	NA	NA
Denmark	10.1	.71	2.8	.20	2,356
Netherlands	82	.71	1.6	.14	1,534
France	9.8	.71	2.3	.16	1,876
United States	5.9	.55	1.1	.10	1,212
Canada	5.4	.61	1.2	.14	1,370

Source: U.S. Senate Special Committee on Aging, 1984. Their data are taken from Organization for Economic Co-operation and Development, and International Monetary Fund figures, as well as individual country reports.

Mr. Biaggi. Thank you very much Dr. Rivlin. I regret I am required to leave at this point. We have some problems with an elderly group in the Bronx which may be typical, I guess, of the problems we have all over the world, which I am supposed to attempt to resolve.

Congressman Tom Manton will act as Chair. We have many a number of questions. I don't think time permits us to pose all the questions here at this hearing but we would appreciate if it's possible you can respond to them, for those that have not been posed for the record, at some time in the future.

Thank you very much.

Mr. Manton. We have the use of the room for approximately a half hour more. I'm not sure whether we'll get through all of the questions but I'm sure the various members of the committee will be posing several questions. I'd like to ask at the outset, Dr. Rivlin, why is it that unlike most other forms of health care, that there really has not been, until recently, any kind of an insurance model evolving to deal with this question?

Dr. Rivlin. I'm not sure that I know the answer to that, although I have thought about it. It is something of a mystery to me because it would seem that long-term care would be an insurable risk. It does not affect everybody. A minority of the elderly are in institutions of any kind, about 5 percent, and that's the kind of risk you can usually buy insurance for.

I think insurance companies have been very afraid to get into the marketing of long-term care insurance in part because their market surveys have told them that people don't want to buy it at any early age. Most of us think that this can never happen to us, that somebody else will be in a long-term care institution. That's a question of education. Companies are afraid that people will not buy insurance until they are quite elderly and have a good ability to predict that they are about to go into a nursing home. Then the cost will be very high. There are ways around that and it is one of the things we are working on in this study together with some insurance industry representations. We are studying whether reasonable cost long-term care insurance is possible.

Mr. Manton. Thank you very much. Dr. Butler, you talked about the need for putting more resources into medical education specifically, the field of geriatrics. How does the United States compare generally with other advanced nations in this regard?

Dr. Butler. Well, with regard to the United Kingdom they have now, I believe, something like 18 departments of geriatrics in their medical schools.

Scandinavian countries, Sweden, Norway, Denmark, have programs in geriatrics within their educational programs and their medical schools.

There are at least two chairs that I am aware of, in the Netherlands they tend to call it medical gerontology rather than geriatrics.

There are, I believe, six professorships of geriatrics in Japan.

So, I mention those countries in particular because of the extraordinarily high numbers of older persons in them and their well-known, up-front cutting edge efforts in geriatrics over the years. I am afraid we are not doing so well. We have one department of geriatrics only, and that's at the Mount Sinai School of Medicine. We have four or five programs of considerable stature at Harvard, at Johns Hopkins, UCLA, Duke. I hope I'm not leaving anybody out, because I'll be in trouble if I am, but the point is that out of 127 medical schools, we just aren't doing very much. The last count I was aware of where electives are given, which is in 45 of those schools, only 2 percent of the students took the electives, so the actual systematic teaching of the medical student is just minimal in the United States, and that's not acceptable. I mean it is not acceptable to any of the elders of this society to not be assured that they have had systematically trained young physicians, graduating, and ready to treat them.

Mr. MANTON. That's distressing to hear. On that note, I have a question for Ms. Codel, who indicated in her testimony that she is continuing to keep her Danish citizenship because of a fear that adequate care will not be available for her in the United States when she reaches that stage of her life that we are all referring to here today. We hear a lot today about tax reform and budget deficits and yet you indicated that in Denmark nearly all citizens pay 52 percent of their gross earnings in taxes, and of course that facilitates the type of health care for the elderly, along with all the other social programs.

Do you, having been here and your children are American citizens and your husband is an American citizen, do you think the American public is ready to exchange those kind of high bracket tax programs for the assurance of adequate health care and other social programs?

Mrs. CODEL. No; I don't think the American people are ready for it yet. It would take a major change in attitudes before you can get to that point. The Danes are willing to make that tradeoff, they have always done it, but it will take a major change in attitudes to implement this here.

Mr. MANTON. Thank you. My colleague, Congressman Siljander.

Mr. SILJANDER. Thank you Tom. It's good to be in New York, and as a member also of the Foreign Affairs Committee this ties in with my interest of other countries and also what we are doing compared to you and what other countries are doing versus what we can and should do.

Dr. Butler, you mentioned your three areas of concern, education, research, and governed private support. If I am not mistaken those are the three areas that you mention.

How do our addressing of these three areas compare to other nations that you studied?

Dr. BUTLER. Well, I have reviewed somewhat the medical training part just now and we are not in the leading category, unfortunately. I wish we would be, and I don't think, as I mentioned earlier, that it would be a very expensive effort. It would be a very modest step. We could train 10,000 geriatricians within 10 years in the program I outlined in the full testimony which I did not read, but which I presented to you. On the research side we are doing rather well, all things concerned.

In Japan, the Tokyo Metropolitan Institute of Gerontology is outstanding. The Soviet Institute in Kiev is also outstanding. There are about 20 different research programs in aging from different parts of the world. It is a relatively new field, it's beginning to take off, but in that regard I would say that we are certainly among the several at the top.

With regard to the private-public initiative, it was interesting to me when I had a recent trip to Romania, which one thinks of as a Socialist country, that they had very active voluntary programs caring for older people in what I guess would be comparable to senior centers in the United States, thus private-public mixes can occur in Socialist countries, and I think we could take some pride in what we have already achieved in terms of private initiatives.

We can, I believe, go a lot further in coordinating State, municipal, Federal, and local community voluntary sector efforts. I would love to see the corporations play a major role. I think they should because of our aging work force and they're going to have to take that into account as they look at the issues of productivity in the next century.

Mr. **Siljander**. On that point, it seems that there is another element that is being considered by Heritage Foundation Research and others in the more conservative line, that private ought to include health care savings accounts, IRA's of sorts, so we can begin taking care of ourselves and planning for our futures. New workers participating in a mandatory private sector health program, yet and still maintaining full health care for all those who are presently in the system and that are relying on the services of the present system. This would be also to Dr. Rivlin as well, is this the type of private initiative that both of you are referring to, or not? Or are we going too far in that type of arranqement?

Dr. **Butler**. I would not speak for Dr. Rivlin, but my own view is that the IRA is important, and the concept of having some initiative that's self-directed is important. However, and this is a very big however, IRA's are not affordable by very many of us. They're affordable by some of us who are more fortunate, but minority groups or people who are in the lower socioeconomic strata really are not the people that are buying IRA's, so that if we are establishing a national public policy that assures us a decent old age, the IRA is not, in my judgment, an effective way to go.

Furthermore, you haven't the foggiest idea when the aging Yuppies hit the golden pond in 2020, what the value of those IRA's are going to be.

Mr. **Siljander**. I resemble those remarks.

Dr. **Butler**. But seriously, in 2020 with the cost of living escalator, which is operative within Social Security, you have an assurance of a constant purchasing bond, as it were, but you have no idea what the IRA is going to be worth, and it could be worth very, very little.

Mr. **Siljander**. I guess Dr. Butler, what I was referring to was, what about an optional system? Make sure the poor and those who cannot afford an IRA, and those who are working there would be a mandatory participation in a health care program, but in the private sector.

Dr. **Butler**. That's exactly what I was going to lead up to. I think the clincher is that we need some initiative for those that want to invest for and have additional amenities, but we have to assure our country, and it's elders, of a basic floor. You know, the vagaries of life are such that someone who may have been very blessed and very fortunate suddenly now is 75 and 80 and whatever resources, however thrifty, however self-reliant they have been, they may be wiped out. So we have to have some decent floor to protect people.

Mr. **Siljander**. Dr. Rivlin, could you chime in on those various concepts that we have placed on the table?

Dr. **Rivlin**. Well, I'm for encouraging the private sector and for encouraging saving. I think we have to be a little bit realistic, however. If you look back over the history of the United States with respect to savings you find that we are not a high saving country. Compared to, say, the Japanese, we are fairly low saving. The various things that we have tried, including very high interest rates and various tax devices, have not changed that fact very much. Our saving, as a percent of GNP has been fairly constant for a very long time.

On the other hand, we are a nation that likes to buy insurance. It may be that calling a saving program insurance, insurance for long-term care, for instance, would have much greater appeal than the savings feature.

Mr. SILJANDER. Just one point, Dr. Butler, you mentioned the National Institute of Health only contributes 2 percent.

Dr. BUTLER. No; it's the Congress that contributes the budget. Of the entire NIH budget, 2 percent of it goes to the National Institute on Aging which is 1 of the 11 of the National Institutes of Health.

Mr. SILJANDER. Just on balance, I realize it's not argument on your point but heart, cancer, mental health, arthritis, National Nursing Institute, drugs, muscular, skeletal, blood and lung, parts of all these other National Institute of Health programs certainly have a direct effect on the elderly. It's not as though only 2 percent somehow affect the elderly. I think that just for the record it is important.

Dr. BUTLER. Actually I did make that point. I agree with you wholeheartedly, but as I say, we are on the threshold of a new understanding of how aging predisposes to disease.

For example, 50 percent of all cancer occurs after 65, and yet there are practically no studies that look at the variables at the biological cellular, and molecular level that leads to a cell suddenly becoming cancerous rather than going ahead and senescing and growing old. So even though the Cancer Institute certainly helps serve the purposes of older people, that perspective is not there.

Similarly, until the National Institute on Aging existed, there had been no attention paid to systolic hypertension in older people, although that's the highest risk factor for stroke. With the advent of the NIA, then in collaboration with the National Heart Institute, came a major systolic hypertension program regarding aging.

Mr. SILJANDER. Dr. Rivlin, I don't want to take up all the time, I know my colleague Mrs. Bentley wants to ask some questions but, since you are certainly from your former position in the CBO and the tax reform movement, and alluding to my friend from New York talking about the tax reform movement and need for simplification, you mentioned fairly directly that the amount of taxes that we as working people are paying will have to go up. There is absolutely no doubt, at least that's my interpretation of your statement. Do you think we are at all ready to go to the 55 percent, I think it was?

Dr. RIVLIN. Fifty-two.

Mr. SILJANDER. Fifty-two, all right, 52 percent rate in this country in light of everything. I ask a similar question because I think it's really of paramount importance because if America is not ready, Congressmen won't be ready, and therefore, we will be forced to look into some of these alternative programs that, if you want to call them insurance IRA's for health that's fine with me, but whatever one terms them I think certainly we have to begin pursuing a change of behavior amongst the American people, because we are not behaved as others have in terms of our percent of GNP in savings. IRA's have helped a bit, but just a very small bit.

Dr. RIVLIN. I have said the total would go up, whether publicly or privately paid, and my guess is that it will be some of each, in the fine American tradition. But no, I do not think that the American public is ready for 52 percent taxes or that they should be. Indeed I am a proponent of tax reform designed to broaden the base of the tax and get the rates down. But as the aging population grows rapidly, particularly after about 2010, we have got to be prepared for a higher bill and we had better think now about how we are going to meet that.

Mr. SILJANDER. Mr. Chairman, may I proceed?

Mr. MANTON. Why don't we come back. We have some time on a second round and we will hear from our colleague, Ms. Bentley.

Ms. BENTLEY. Thank you Mr. Chairman. I have had personal experience in all facets of elderly sickness. My mother, who suffered a stroke at age 88. My mother-in-law who suffered Alzheimer's disease. A close friend who had no relatives. My husband and I took care of her. She had her leg cut off and went to a nursing home and had to spend down so that she could qualify for Medicaid before she died. So, I am familiar with all of it and there is one question I have in my mind as I am listening here today.

If the United States is so bad, why does everybody want to come to the United States? Can anybody answer me? Mrs. Codel.

Mrs. CODEL. For many people I think the United States stands as a land of golden opportunities. When you are young you never think about you are going to get old. As a matter of fact, you are never going to grow old, you are never going to become sick. I don't think you think in those terms when you are young and you have just come over and you want to build a future for yourself.

For my part I kept my Danish citizenship for the past 11 years I have been here, but it did not occur to me that that was the only reason I was keeping it until I became more familiar with the health system here.

Ms. BENTLEY. Ms. Havens, you talked about the Canadian system and yet there is an article in the New York Times that points out that a Saskatchewan hospital reported 6 month waits for 45 patients considered urgent candidates for open heart surgery. Is that good service when you are criticizing what we have versus that?

Ms. HAVENS. Two points, No. 1, in that we are 10 provincial systems, I would hesitate to comment on what may be occurring in Saskatchewan being that I am from Manitoba.

Second, I hope my comments were not interpreted as being criticism of the U.S. system, but rather I hope could be looked upon as being useful in the development of what would undoubtedly be a U.S. system which would encompass, I presume, elements of all of the systems that exist. A program which who comes along later, and we have certainly had experience with that, the one which comes along after can generally take the experience of those that have gone before and very often the third widget is better than either of the first two. I hope that my comments would be interpreted in that light.

Ms. **Bentley**. Well, we'll accept it. I just want to also point out that a New Brunswick hospital keeps 30 beds empty to save costs despite a surgical waiting list of 1,400 patients up there: Ms. Greengross, what I did before I went into Congress was I was an international business consultant, so I have friends and contacts in Great Britain as well as Denmark and other places and I have had the opportunity to contact them over the years and know what has happened to them and one of the friends of mine who died from kidney failure in England, in London, was because she was up in years and they would not give her the dialysis machine. There is an article in the Wall Street Journal which happens to refer, it's coincidental, to that. It says, in the United States, 250 people in every million can be treated for kidney failure if need be. Britain can treat perhaps 40 in a million and younger people are given preference. So if you are British and 55 years old and your kidneys failed, the health service probably wouldn't give you a transplant or a dialysis machine. If you were 75 or older it definitely wouldn't. In other words, you would die.

So, as I say, my friend was a victim of that because she was up in years. I just bring that out in that I know we have to make improvements in this country, and I think home health care is very important. I think one of the recommendations that Dr. Rivlin made is probably one of the best I have heard this morning. Namely, that we need to do more on nutrition and exercise and preparedness and I don't think that we have spent enough effort in this country to emphasize the importance of nutrition. I think that is something that this committee should take up, Mr. Chairman, on a broad scale. Prevention is much better than having to worry about the cause later.

Dr. Butler, you were talking about what the Government should do. May I ask what the AMA is doing in the line of urging doctors to train in geriatrics, et cetera?

Dr. **Butler**. I am delighted you asked that since I am not a member of the AMA. It's one of those private sector institutions which I am afraid one might have hoped for better, and I think it illustrates the failure in the private sector, because if you want to look at something that is disorganized and chaotic, it's fundamentally American medicine which has really failed to take proper care of the population either through up front policy initiatives to deal with long term care, to come to grips with nursing homes, to come to grips with health promotion and disease prevention, which you have stressed.

For example, it took a long time for the AMA to deal with the tobacco industry. It still hasn't really thoroughly done so, and it has continued to be neanderthal in it's attitudes. I mention this because I think the private sector has a great deal to answer for in it's failures to meet the many health needs of our country.

Ms. **Bentley**. Well, what have the medical schools done?

Dr. **Butler**. Medical schools have done a little bit, but not much and that's in part a function of the nature of the way in which the private sector also functions. Namely, the private sector is a function of foundation support, or of individual philanthropy. Twenty percent of all of the medical school budget comes from the faculty practicing, seeing patients in order to support the medical school.

Another 20 percent of the budget comes, for example, from research grants. About 40 percent comes from Medicare. Medicare cutbacks will profoundly effect hospitals. Forty percent of hospital revenues derive from Medicare. With Medicare cutbacks we are going to see a continuing cutback of services for people of all ages because the cuts are going to be in the bloodbank; they're going to be in the laboratory; they're going to be among nurses. In fact, if you read the New York Times this morning you will see that there are already going to be cutbacks as a result of Medicare and the services that you are beginning to see in American hospitals are a kind of gentrification in which those that are better off are getting very good services. They are getting the newspaper in the morning. They are getting a good gourmet breakfast and gourmet meals during the day, but average citizens in the same hospital are not getting the same decent care. So I think we have got a lot to discuss when it comes to the private sector initiatives or the failure thereof, with regard to decent health care in the United States.

Ms. BENTLEY. Are you saying that for all hosoitals that certain ones get certain foods and the other's don't, are you saying that as a broad scale statement?

Dr. BUTLER. I can hardly say that I have visited 7,000 hospitals recently in the United States, but it is clear that there are decisive cutbacks. There are delays in admission, particularly of, just as you were pointing out in Canada, we are seeing older people who are not admitted because they are not attractive cases. They have multiple complex physical, social, nursing problems. I saw a patient not too long ago, a woman in her seventies, 74 to be precise, who was confused, who was starting fires in her apartment. Not on purpose, she was confused. Was she a social admission? Was she a medical admission? The answer is that she is not someone who would ordinarily be reimbursed because of the curious definition of a medical problem, even though she has a significant memory problem. That is a function too, of the way in which many of the regulations, both at the State and Federal level, function.

I am afraid that our hospitals are beginning to show signs of some deterioration of care, especially of older people, which is the natural constituancy of this committee.

Ms. BENTLEY. Have you made any approaches to the AMA to talk with them, to open any doors with them?

Dr. BUTLER. I had always been available to talk to the AMA and the AMA has, from time to time, called on me, yes. But I have not found them to be an exceptionally innovative organization.

Ms. BENTLEY. I think Mr. Chairman, that we should have the AMA at our next hearing as well and hear their side of it, if we may please.

Mr. MANTON. I will suggest that to the Chairman.

Ms. BENTLEY. One other comment Mr. Chairman, I'd like to make, is a question perhaps. Again, if the United States is so bad, why are we getting doctors from every nation in the world who want to settle here? I have them. I am from Baltimore which is a great medical center and I can tell you that we have many, many, many groups of professional people who settle there from all over the world rather than going back to their countries.

Dr. **Butler**. No. 1, I agree with you that this is a great country and I don't think anyone including our foreign visitors, suggested that this is not a great country that is doing many good things.

No. 2, we encourage by our policies, the bringing in of foreign doctors because American doctors do not want to work in nursing homes or public mental hospitals, for example. So by public policy, by Congress and by executive branch of Government, has encouraged the entry of physicians in this country.

Moreover, I know many, many doctors from all over the world who love their countries and many people who do and remain there as vibrant, effective, patriotic citizens of their country, just as we are in our own, so I don't think it's correct to suggest that doctors are lunging to get into the United States.

Ms. **Bentley**. How many American doctors have gone to other countries to work?

Mr. **Manton**. I think we are drawing down to a close here in about 5 minutes, and if I could just reclaim the time of the Chair, perhaps we can make a quick second round.

I would just like to say, before I ask a question or two, that it was not my understanding of any of the testimony, particularly of our foreign visitors, that the testimony was in any way critical of U.S. policy, but rather in a more positive sense discussing what things are happening in their own countries. Of course that's the purpose of the hearing to take that type of evidentiary testimony for the record and perhaps be able to build on it.

Dr. Baro, I understand that you have traveled widely in the United States, studying our mental health care system and in the very short time that we have, what suggestions could you make for improving our system?

Dr. **Baro**. Thank you, Mr. Chairman. In the United States, as far as mental health services for the elderly are concerned, generally speaking the services seem to be rather large and often understaffed. In most nursing homes mental health care components are not available.

Often the movement of deinstitutionalizing the elderly out of mental hospitals throws them into the community without support or aftercare. Also, the number of experiences with mental health in the field of home care are very few.

On the other hand, I think you have excellent examples of innovative programs. The mental health care of the elderly is really excellent. You have special initiatives from the Veterans' Administration, such as, the hospital based home care, Community Residential Care Program, Respite Care Programs, and so on. I know very well Dr. Butler's program in Mount Sinai. The Berkely Rehabilitation Center in White Plains, and more examples could be given where you have excellent approaches and I think you learn from these, your own examples, as from our countries.

Mr. **Manton**. Thank you. My last question will be to Ms. Greengross. There are some that argue against publicly financed program and they make the argument that the families will do less if these programs are more available. Do you want to comment on that?

Ms. **Greengross**. Yes, Chairman. I think that the research that has been done to date in many countries has shown that families care as much, if not more, than they used to, but there are less children very often, to do the caring. We ask families to care today, with medical advances, for a much longer period because, fortunately, rather frail people can be maintained in the community and stay alive for much longer. The good will and the caring attitudes have the sort of myth that the family doesn't care as it used to. If I can just quote you one study in London in the East End which is the sort of solidarity area where we imagine this all took place. The study found that at the end of the last century for every one elderly person cared for by the family at home there were 50 who were either in the workforce or in the community.

I think if we want to draw on the resources of the carers and the family we have to be sure that we just enable them to care. Could I also just end by saying, it's the course we admire, at least if I may speak personally, we admire your openness and your willingness to hear about other countries. That is one of the reasons we admire the United States so much and if we draw on the best sort of examples that community care as I was doing, through some interesting examples in Europe, it isn't to defend the very bad example of rationing and delays and so on, and edges in my own country which I deplore and which we campaign against continually and consistently. So, Mrs. Bentley, so it's no criticism of the United States. I am very pleased we are able to discuss this with you.

Mr. MANTON. Thank you very much. I think we probably have time for about a 1- or 2-minute second round for Mr. Siljander and Ms. Bentley, and then we will have to conclude.

Mr. SILJANDER. Mr. Chairman, I would just like to make one quick motion that the record be kept open for 2 weeks for additional information to be submitted, a unanimous-consent request.

Mr. MANTON. Without objection. So ordered.

Mr. SILJANDER. Second, I'd just, as a closing comment, there is really not enough time to press into further questions on panel 1, but I would reiterate some of Ms. Greengross' comments, that I didn't necessarily take your comments as an attack or criticism of the United States. We have our problems and obviously you have yours.

We are looking toward improving our system. I don't think I'd want to improve it with the 52-percent tax frankly, at least from a personal point of view, so there must be other alternatives. I don't think most Americans would either. In fact, I'm sure the vast majority of Americans would not either.

We are a land of opportunity for the young and I believe many of the elderly as well. The elderly rate is growing at an alarming rate. Alarming in the sense that something needs to be done to deal with the concerns of health care in a stable, reliable light in an environment of the United States. So, we appreciate your input a drawing from your assets and also trying to learn from our mistakes and the mistakes that have been made in other countries, so I hope we can look toward more of a private sector orientation, that's my point of view, because it seems that the Socialist systems that are merely Socialist have been engulfed in either high taxes or extreme inefficiency and failures, and one last comment for Mrs. Codel.

Just to comment to you, you can respond if you like. I read your testimony that there is no means test or family responsibility in Denmark, and I did see, as Mrs. Havens comments, that in Canada that is a very important element. So, here is an example with two contradictions in systems and I certainly feel that the family, the neighborhood, is vitally important in the church and other elements of the community in maintaining reasonable attention and care toward the elderly. I can see why the tax rate is 52 percent in that regard.

I thank you very much, Mr. Chairman, for yielding another 2 minutes to me.

Mr. MANTON. Ms. Bentley.

Ms. BENTLEY. Mr. Chairman, I was trying to just bring out that no system is perfect, no country is perfect and I just didn't like the United States to be the one that was getting all the complaints and pointing out. I like to defend the country.

Also, I echo what Mr. Siljander had to say here, all of his remarks this morning. We do need to improve, we know that, and I think a way to develop more home care is very important.

Thank you.

Mr. MANTON. Thank you Ms. Bentley. This will conclude the Select Committee on the Aging's hearing here in New York. We thank all of the panelists for being with us and all of the spectators for staying with us so long.

Thank you very much.

[Whereupon, at 12:55 p.m., the hearing was adjourned.]

APPENDIX 1

LONG TERM CARE FOR THE ELDERLY: THE COMMUNITY CARE SCHEME

David Challis and Bleddyn Davies

Authors

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The article describes the full evaluation of the Community Care Scheme for the elderly in Kent. The evaluation compared the relative cost-effectiveness of the scheme for clients and carers with the range of services which would otherwise have been received. It is argued that effective case-management by a key worker is an essential feature of more effective home care for the very frail elderly and that the case-management role is an appropriate model of social work for other long term care groups. The new scheme appeared particularly appropriate for the extremely mentally and physically frail who were living with others and for the less frail, socially isolated elderly person prone to minor psychiatric disorder.

Demographic pressure and constrained budgets have been major contributory factors in the development of new care strategies for frail elderly people (Ferlie et al, 1984). These responses reflect the emergence of a significant group of elderly people who require long term care in their own homes. Such people and their carers have a wide variety of needs arising from such factors as the nature and type of physical frailty, the availability of social support, mental health and the time and duration of required care. However, this variety of need is rarely matched by an equivalent variety of service provision since effective long term care demands much greater flexibility than is usually available to construct individual packages of care. The services that are available tend to be highly fragmented, provided by a number of different sources and poorly co-ordinated with no-one unambiguously responsible for this task at the level of the individual case. One study described the resultant care as "... an unco-ordinated set of discrete and relatively autonomous parts ... the care which any individual old person receives is to a major extent fortuitous" (Plank, 1977, p.12).

The Community Care Scheme (CCS), developed in several local authorities, provides an organisational framework within which social work staff can develop sensitive and appropriate alternatives to residential and long-term hospital care. The scheme involved the decentralisation of control of resources to individual fieldworkers, with defined caseload and expenditure limits to ensure accountability, so that more flexible responses could be devised and the fragmented services integrated into a more coherent package of care. The underlying rationale of the scheme and an interim evaluation have been discussed in an earlier paper (Challis and Davies, 1980). In this article the central findings of the full evaluation of that initial pilot project are discussed.

1. The Basis of the Scheme

The Community Care approach attempted to tackle both the problem of inappropriate service content and to reduce the fragmentation and lack of co-ordination of services using two separate but related strategies. These were:

- greater flexibility of response to need so as to enhance service context
- improved case-management through the clear responsibility of a key worker for a defined caseload to integrate services into a coherent 'package of care'.

A number of devices were developed to provide a work environment conducive to these tasks:

a) The elderly people receiving the scheme were to be those whose needs were at least sufficient to justify admission to residential care.

b) The staff appointed to the scheme were to have smaller caseloads than is common in work with the elderly people, 25 to 30 cases, and more akin to those of people working with vulnerable children. This was necessary to enable them to undertake the full range of long-term care tasks - raising suitable referrals, careful and detailed assessment, planning a complete package of care, liaison with other agencies, monitoring, providing support and advice to elderly people and their families and developing community resources such as lodgings or neighbourly help. It was further expected that specialisation in work with one client group would lead to greater knowledge and subsequently improve the quality of care.

c) More experienced personnel were to be recruited as fieldworkers in contrast to the too frequent practice of allocating work with the elderly to unqualified and inexperienced staff (Stevenson and Parsloe, 1978).

d) To extend the range of alternatives available, the workers had control of a decentralised budget, which they could use to develop services or provide for improvements in an elderly person's quality of life. The total social services department expenditure was notionally charged to the budget along with actual additional expenditure. To balance this greater autonomy with the need for accountability, expenditure per case was initially limited to two thirds of the cost of a place in a residential home, any additional expenditure requiring line-management sanction. This knowledge of the unit costs of different services introduced a new awareness of the relative costliness of different courses of action into fieldworkers' decision-making.

e) Where possible it was arranged for the scheme to be co-terminous with other relevant services such as hospital catchment areas. This was to foster good liaison and constructive exchange relationships at the individual case level with community nursing and geriatric services. Within different local authorities there has been some degree of organisational variation. The original small team of three social workers was established as a separate unit to cover the same district as an existing area team. Subsequent developments have varied, some adopting this mode of deployment, others have located staff in area teams or operated from a residential home.

2. The Evaluative Research

The central questions which the research sought to tackle can be summarised in two broad areas:

Social Care Process Issues: These included questions such as: How did the team respond to the opportunity of greater flexibility and control of resources? What could be learned about the roles and tasks of fieldworkers in long-term care? What kinds of care strategies are appropriate for elderly people in different circumstances?

Cost Effectiveness Issues: These included questions such as: What was the effect of the scheme for elderly people and their carers compared with the usual range of services? What was the cost of care? For whom is this type of provision the most appropriate use of resources?

In order to provide a comparative basis for the evaluation, the effects of care for those receiving the scheme were compared with the experience of similar cases from adjacent areas which were part of the same health and social care system. This design was 'quasi-experimental' with post-selection matching of cases and is described in detail elsewhere (Davies and Challis, 1981). Independent assessment interviews were undertaken with elderly people and their carers immediately prior to receipt of the service and these were repeated after one year. Individual cases were matched by factors likely to be predictors of survival in the community. These were age, sex, living group (household composition), presence of confusional state, physical disability and receptivity to help. As a result of this process 74 matched pairs receiving the new service and standard provision could be identified for comparison.

In addition to assessment interviews, the different patterns of response to different kinds of problem were carefully monitored as were the precise amounts of service received by each case.

3. The Operation of the Scheme

It proved helpful to consider activities of the case-management process in terms of the stages of care which had to be undertaken to provide for an individual elderly person (Steinberg and Carter, 1983). In this way considerable light could be shed upon the roles and tasks required for social work in long term care, and the varied response to different types of problem can be more readily identified. The case-management proces can be broken into five stages: Raising Referrals, Assessment, Care-Planning, Monitoring and Closure.

a) Raising Referrals

This can be a difficult task for any new service which is attempting to establish itself. Both 'case-finding' and 'screening' proved to be important aspects of the referral process. The former was intended to ensure that a high proportion of those for whom the service was deisgned actually receive it, and the latter to ensure that a high proportion of those who receive the service are those for whom it was designed. Since the scheme had been established in an Area Office as an alternative to residential care, initially referals came via that team and screening was tackled by careful consideration of each case with the referring fieldworker. The identification of appropriate referrals and redirection of the inappropriate, proved to be less of an issue once the scheme was established and referral agents were more aware of its existence and purpose. Indeed, the threshold of entry to the scheme, that of requiring admission to residential care, came to be defined as only a minimal criterion in recognition of the high level of need of cases being referred.

As the scheme progressed and contacts were made with other services in the community, particularly the health service, referrals were made of cases previously unknown to the Social Services Department. These tended to be of two kinds. First, people requiring a level of care greater than that usually provided in a residential home, such as those confined to their bed, usually receiving nearly all their help at great personal cost from a spouse or relatives. The second group tended to be those elderly people suffering from functional psychiatric disorders for whom the existing service response is often inadequate (Foster et al, 1976).

b) Assessment

The separation of assessment from care-planning was an essential element of the philosophy of the scheme, to avoid routine service based assessments. It was noticeable that the wider range of responses afforded to social workers by possession of a decentralised budget made possible improvements in the breadth and depth of assessment. The approach was problem-oriented rather than the assessment of elderly people in relation to their suitability and eligibility for an existing service. Thus the identification of needs was separated from the means of tackling them. Providing social workers with the opportunity to respond in ways that reflected the individual needs of clients appeared to act as an incentive to undertaking more careful assessments.

c) Care Planning

In many cases, this involved a reconsideration of the appropriacy of the services which a person was already receiving, both in terms of the amount of provision and also with regard to timing so that the services could be re-arranged into an integrated package designed for the circumstances of the individual. For some clients, the team needed to respond sensitively to overcome an elderly person's diffidence or reluctance to receive services and to introduce the often substantial components of care at an appropriate pace. The major new resource upon which the budget was deployed, in combination with the range of existing services, was the use of local people, whether or not previously part of an elderly person's social network, as "helpers" to perform specified tasks for clients. The actual fee paid was agreed between the social worker and the individual "helper" and varied according to the task to be done, the characteristics of the elderly person in question, the time at which the task was done and the circumstances of the helper. Payment was not for a given time but for the performance of the task thereby permitting flexibility not only in what was done, but how it was done. Clearly the provision of human caring resources was an essential requirement for most elderly people, although it was noticeable that this extra help was usually recruited by the team or already part of an elderly person's social network and was not provided through the private sector or voluntary agencies. "Helpers" have ranged from those with previous caring experience, either professionally such as retired nurses or home helps, or informally within their own families, to those with room in their lives which they wishes to fill with worthwhile activity, such as young housewives or the recently bereaved. They were often not in a position to enter the labour market (Qureshi et al, 1983).

Where helpers were introduced to elderly people as part of a package of care the tasks which they undertook were made explicit in a "letter of agreement" which in effect clarified the expectations of the social services department in providing a fee. The contract spelled out the tasks to be undertaken in care and the objectives of care, providing legitimacy and purpose in the early phase of client/helper contact. This procedure was to make the commitment regular and explicit, providing essential reliability for the elderly person and avoiding the danger of uncertainty and lack of direction for the helper (Davies, 1977). Care was taken to try and "match" elderly persons and helpers to attempt to ensure that both relational and instrumental needs were met. The tasks which helpers have undertaken range from immediate practical help with tasks of daily living when other help was not available to the social and therapeutic. These latter activities, such as accompanying a phobic old lady on walks of gradually increasing length while providing reassurance, helping to reactivate old interests and abilities or more simple companionship, constituted one fifth of the specified tasks. These extra care inputs were provided as part of an overall care plan, integrating the activities of several agencies, formal and informal carers.

The budget was also used in other ways. One of these was the development of small day-care groups of four or five elderly people in a helpers home to undertake social and rehabilitative activities. This proved particularly useful for people unsuited to more traditional forms of day care such as the mentally frail, or those for whom a lengthy ambulance journey was uncomfortable. Short term care in helpers' homes was also arranged following periods of illness or hospitalisation. Aids or hardware which are not usually available were purchased. These included automatic electric kettles and oil-filled electric heaters for the use of demented elderly people, making it possible to reduce hazards such as a gas supply. Other items included special vacuum flasks which can be used by those with arthritic hands and craft materials to encourage both rehabilitative and recreative activities at home.

d) Monitoring Care

Careful monitoring of the appropriacy and adequacy of care was part of the continuing long-term responsibility for cases. It involved regular re-assessment, careful co-ordination of the formal and informal network, adjusting the mix of services where necessary and direct social work activity such as dealing with stresses and conflicts experienced by carers and providing support through experiences of loss. A simple tool was developed to aid the monitoring and co-ordination of what could at times be a complex network of care. This was a chart being a matrix with the seven days of the week on the vertical axis and critical periods of the day such as getting up, lunchtime and early evening on the horizontal axis, making it possible to identify who was providing for the person's needs and when there were critical periods of solitude. This and other recording documents are discussed in Challis and Chesterman (1985).

It was noticeable that for some of the more intractable problems in care of the elderly, which are often unresponsive to the usual range of services, additional strategies of management were developed by the team. These are discussed in greater detail in Challis and Davies (forthcoming).

(i) Problems Associated with Dementia: Care of the dementing elderly is perhaps the most demanding problem facing any home care scheme. The only evidence of predictors of success or failure in managing these patients at home is the Newcastle study which identified the importance of the degree and type of social support (Bergmann et al, 1978). Nonetheless the scheme appeared to have some degree of success in terms of the establishment and maintenance of care and the reduction of risk to these individuals who were over one quarter of the caseload. The strategies adopted and lessons learned can be undertsood in terms of four factors. These were gaining access or "entree", "process-risk", "event-risk" and "patterning care". Gaining access or "entree" to the individual and making help acceptable was an essential pre-requisite for providing care which is not rejected. This might require persistence or an immediate response to particular behaviour problems, identifying ways of establishing rapport and communication, a willingness to initially provide help where need was perceived by the elderly person rather than where the need was evidently greatest to avoid rejection. Identification of the positive elements of retained ability as well as those areas of increasing deficits could provide a basis for building an effective support system. "Process risk" refers to the likelihood of increasing self-neglect, decline and reduction of coping skills, often a downward spiral. This was tackled by the organisation of care to provide supervision, food, medication and stimulation to arrest nutritional and social decline. "Event risk" refers to the loss of coping skills where normal sequential acts of daily living are not completed in their entirety, such as turning on gas taps and failing to light them, thereby causing a hazard to the elderly person and their environment. This was tackled by modifications to the physical environment such as turning off the gas supply, identifying any regular behaviour patterns and establishing routines with close supervision to reduce the risk of wandering. Whilst many individuals will exhibit a mixed picture of risk, the distinction has proved helpful as it serves to discriminate between different types and foci of intervention. The fourth element was "Patterning Care". This was the construction of a clear and regular pattern of care based initially upon the positive elements retained by the old person despute their mental disability. The pattern had to be meaningful within the old person's daily routine, or depend upon external cues such as light and dark, night and day. Where there was no such routine attempts were made to create one, for example, associating particular activities with retiring to bed, and perhaps providing regular activity at an appropriate time, so as to provide the person with a more predictable and apparently secure environment. In addition reality orientation approaches (Woods and Holden, 1981) were employed. Helpers were enjoined to convey relevant information, such as the day of the week or the meal being eaten, in every interaction with the elderly person. With these cases a greater degree of direction was required of the social worker who had to take responsibility for providing a certain level and type of care and making it acceptable to the elderly person. Consequently the elderly person's decisions were less of a positive kind and more of a veto, as in the protective approach advocated by Wasser (1971).

(ii) Other Psychiatric Disorders: Elderly people suffering from psychiatric disorders such as depression, anxiety and alcohol-related problems are frequently recipients of insufficient resources in comparison with otherwise similarly needy people (Foster et al, 1976). It appeared that experienced staff would more frequently identify these problems and liaise closely with health service personnel to obtain appropriate treatment. Consequently, with additional social support and stimulation accompanied by an attention to detail, a positive response was observed in a considerable proportion of cases with depressed mood. A small but significant group, eight cases, suffered with problems of excessive alcohol intake, often in association with depression and social isolation. Half of these represented longstanding drink problems persisting into old age and the rest appeared to be of recent onset in response to social stress. With the former group, close support and supervision to maintain a level of acceptable or controlled drinking was reasonably successful, in part because sources of supply were known and could be controlled, and in addition attempts were made to mitigate the ill-effects of drink by ensuring the provision of an adequate diet. A similar strategy was adopted for the late onset individuals but the social workers also made efforts to tackle the precipitating stresses such as isolation and loneliness.

(iii) Risk of Falling: Risk of falling is one factor which makes a considerable proportion of elderly people liable to enter residential care. By its very nature the problem is unpredictable. Such uncertainty is a cause of concern to both an elderly person and their carers and may lead to an intolerable level of anxiety only resolved by admission to care. This uncertainty often results from the knowledge that visits are unpredictable, at infrequent intervals and the elderly person's expectation that if they fell they would have no knowledge of how long they would remain on the floor. The focus of intervention, apart from any alterations to the physical environment which might reduce the likelihood of falling, was tailored to the reduction of this threshold of fear. At times this was accomplished by a regular, predictable pattern of visiting organised on a local basis, making the level of risk acceptable to the old person and their carers, in the knowledge that should they fall a visitor would be coming at a certain time. The risk of secondary damage from the "long lie" (Hall, 1982) could thus be greatly reduced, and consequent pressures from relatives and other professionals for an institutional solution lessened.

(iv) Supporting Carers: On occasions, existing services such as day hospitals, day-centres or home help cannot be fully effective in meeting need, perhaps because an elderly person is too sick to attend or because a carer does not desire help with domestic tasks. Indeed, in some areas domiciliary services are focussed away from elderly people with families. In certain of these cases it was necessary to begin care-planning by working towards the creation of realistic boundaries for carers to reduce the effects of a gradually increasing burden and thereby to set limitations to that commitment. One way of avoiding the polarisation of care for one individual was for the social worker to convene a family meeting and involve all the relevant parties in care planning as described by Ratna and Davis (1984).

The use of local people as helpers provided the social worker with the flexibility to respond to a range of carers' needs from simply sitting in with an elderly person to a combination of services taking over the full care responsibility for several days each week. It appeared that the provision of appropriate help for carers at the right time enabled them to continue caring substantially longer than would have otherwise been the case, indicating that it is indeed possible to establish a relationship of complementarity between formal and informal care.

(e) Terminating Care at Home

In the early period of monitoring the scheme, decisions to terminate care at home when this was not the elderly person's choice, proved to be relatively rare. However, in the longer term this is a crucial area for any home care scheme attempting to provide an alternative to institutional care, since many individuals' health will deteriorate to a point where their needs are greater than conventional residential care. Consequently there was a need for the case-managers to continually balance the desires and needs of the elderly person and their carers taking into account the relative risks and levels of tolerance.

4. Outcomes and Costs of Care

These issues can be considered in three sections: destinational outcomes - the location of clients after care for a given time period, quality of life outcomes - the effects of care for clients and carers, and the issue of costs and cost-effectiveness.

a) Destination of Cases

The location, defined as place of residence for cases still alive, over a three year period for 74 matched pairs of elderly clients is shown in Table 1. It can be seen that whereas 69 per cent of those receiving the scheme remained in their own homes after one year only 34 per cent of the comparison group did so. This difference appeared to be largely explained by different rates of admission to local authority homes and of death. These findings are broadly similar to those of earlier analyses (Challis and Davies, 1980) although the death rate observation is new. However, since the death rate effect was also present in larger unmatched samples of cases, 15 per cent compared with 28 per cent, it is unlikely to be an artefact of the matching procedure. No differences were evident between the matched groups in terms of factors likely to be associated with poor survival chances such as functional status, incontinence, poor memory or other correlates of organic brain disease. Indeed, if anything, the level of frailty was higher for the Community Care group. It is clear that the initial advantage of the new scheme continued over the subsequent two years. The death rate, that is the proportion of surviving cases who died, was similar for the two groups in the second year, 14 per cent and 12 per cent respectively, but in the third year again was lower for the Community Care scheme, 9 per cent compared with 21 per cent. Examining admissions to residential care, in the second and third years entry to private residential care increased in both groups, although the relative advantage of the scheme continued in that a lower proportion were in residential care overall. By the third year, there was a slight increase in the Community Care admissions to hospital for long term care. This trend was to be expected since a number of individuals were remaining in the community until their health made long-term hospital care a more realistic option than residential care.

The observed differences in admission to institutional care are what might reasonably be expected from a scheme to improve care at home. There seemed to be two possible explanations for the unexpected differences in survival rate. One appeared to be the reduced 'relocation effect' (Yawney and Slover, 1973) since cases receiving CCS were less likely to enter long term institutional care. Of the 15 community care cases who died in the first year, only 3 (20 per cent) had made a permanent move to institutional care, compared with 13 (41 per cent) of the 32 control group cases who died. This is consistent with relocation accounting for at least some of the difference in survival rates. A second possible explanation was the influence of extended social support. A number of studies have indicated that the presence of a confidante can mitigate the ill-effects of social stresses (Brown and Harris, 1978; Miller and Ingham, 1976) and there is some evidence that social support may also affect survival rates (Berkman and Syme, 1979; Parkes, 1980). Since the work of the scheme had focussed not simply upon practical requirements of the elderly people, but also their emotional and social needs, this may have played some part in survival. At follow-up survivors living their own homes were asked whether they had anyone in whom they could confide. Whereas 58 per cent of the comparison group could identify no confidante, only 15 per cent of the community care group felt this to be the case. Much of this difference was accounted for by the greater number of community care cases who would confide in their social worker or scheme helper.

b) Quality of Life and Quality of Care

The changes noted on a range of quality of life and quality of care indicators are shown in tables 2 and 3. In each case the mean change, the difference between the first and second assessment for each variable is shown and the significance level of that difference, tested by analysis of variance.

It can be seen that there were significant improvements both in subjective well-being and quality of care for the recipients of Community Care compared with those elderly people in receipt of standard services. Only one of these indicators, "anxiety" failed to reach a satisfactory level of significance. This was because much of the evident anxiety was associated with risk to personal security amongst those who were socially isolated and at risk of falling. A higher proportion of these cases in the control group were admitted to residential homes, which effectively reduced the anxiety associated with this risk. Hence there was no significant difference between the Community Care Scheme and standard provision for this factor. A range of indicators of quality of care were more significantly improved for individuals receiving Community Care. Other analyses demonstrated that there was a lower rate of decline in functional status amongst the Community Care group, which could in part be attributed to close liaison between the scheme social workers and the Geriatric Day Hospital. No such close contact occurred for the control group cases.

The elderly people referred to the scheme tended to be socially isolated, reflecting the characteristics of a retirement area (Karn. 1977). Nevertheless, in about one quarter of the cases there was a readily identifiable principal carer, nine tenths of them female. The major difficulties experienced by carers were mental stress, chronic tiredness, disrupted social life and household routine. The outcomes for carers are shown in Table 4.

Whereas the Community Care Scheme appeared to be significantly more effective in reducing subjective stress amongst carers, there was no difference between Community Care and the control group in relation to reduction in practical demands on carers, such as effects upon employment or social life which were reduced equally in both groups. This can be seen from Table 4 where three of the subjective factors approach an acceptable significance level despite the small numbers, one in five, of cases with principal carers. The explanation for this appeared to be that, in the control group, elderly people with carers were particularly likely to enter institutional care. Entry to institutional care and effective support at home likewise reduced the difficulties in social life or employment. However a carer who has, through lack of any other option, felt compelled to place an elderly relative in institutional care to resolve their difficulties may still experience guilt and distress. Thus, one family in the comparison group, having arranged for their mother to enter a residential home as the only available response to their difficulties, felt it necessary to arrange for her to move back to their home again despite the problems, due to her distress. On the other hand, a neighbour of an elderly woman, experiencing difficulties in providing care, felt happy at continuing with support from the Community Care Scheme, in the knowledge that further help was available should she require it and that she was not in danger of facing sole responsibility for care.

One fear that had been expressed about the development of the scheme was the danger of a 'commercialisation' effect (Hirsch, 1976). That is, by providing payments to members of the community to act as helpers the scheme could reduce people's willingness to care informally. However, it can be seen from Table 5 that over one year that there was no evidence of this effect. Indeed, in some cases the presence of additional support seemed to be a factor which made carers less likely to give up.

c) Costs and Cost Effectiveness

The costs of care for those receiving the scheme and the comparison group were compared at 1977 prices, the year in which the scheme commenced. In Table 6 are shown the costs incurred by the Social Services Department, the National Health Service and Society as a whole over a one year period. The figures are shown both as an annual cost and also per month survived, the latter figure controlling for the difference in death rate between the two groups. Social Services Department costs included residential care, day care, home help, meals on wheels, social work time, aids and a number of other smaller categories. National Health Service costs included periods of hospital care, day hospital, community nursing and aids. It was not possible to include family practitioner costs in the NHS analysis, but the differences between the two groups are likely to be small.

Social opportunity costs included care from health and social services, the value of housing and other resources used by an elderly person and financial costs borne by carers such as having to forego employment. The capital costs of hospitals, residential facilities and housing were discounted over a 60 year period at a rate of 7 per cent. Because of differences in accounting procedures, the social services department costs allow for capital elements but those for the health service do not. Therefore, in the social cost calculations a notional capital estimate was made for hospital facilities based upon an assumption of the cost of upgrading the wards (Wright et al, 1981).

The results suggest a small cost advantage to the social services department from the community care scheme. This advantage is, of course, relatively greater for the monthly cost figure. For the National Health Service however, greater longevity tended to increase costs, the scheme costing slightly less when standardised per month but more on an annual basis. It was noticeable that for both these agencies, the costs were composed of very different elements. Significantly less residential care and long stay hospital resources were used by clients of the community care scheme, although they used domiciliary services, acute hospital services and day hospital more frequently. In the care of the very dependent, the CCS appeared to be a substitute for long-term hospital care, producing cost savings to the health service for these patients. The social opportunity cost figure yields conclusions similar to the health service, a slightly higher aggregate for the CCS although lower costs per month. A follow up of these cases over a four-year period will help to determine whether the influence of varied survival rates and different use of housing and residential facilities cause the cost of care at home to become significantly greater over a longer time period.

The comparison of average costs and aggregate outcomes can however, only provide a partial explanation of these results. It could be argued that social work research has been bedevilled by over-general research questions such as: "Is this mode of care less costly?"or "Does this form of intervention work?", when the crucial question for fieldworkers, planners and policy-makers is: "For whom is this mode of care the most cost-effective response (the best use of resources)?" The answer to this question requires simultaneous examination of the relationship between costs, the characteristics and circumstances of individuals and the outcomes of care. This was tackled by the use of multivariate statistical techniques to identify the influence upon variations in cost of individual client circumstances such as health, dependency and social support and two outcomes, subjective well-being and quality of care. The resultant cost equations clarified the effect of individual characteristics upon the process of care and could be used to predict the cost of achieving different levels of outcomes for different types of case.

Whilst it appeared that many clients were well-served by the CCS, these analyses suggested that there were two types of case for whom it was particularly cost-effective, both for the Social Services Department and for society as a whole. The first was the extremely dependent elderly person with both mental and physical frailty who receives a considerable degree of informal support. This is consistent with the conclusions of Bergmann et al (1978) who suggested that to focus home care resources on the demented elderly with informal support would be most productive, in view of the poor prognosis of those without informal support. The second group was the relatively isolated elderly person, with only a moderate degree of dependency, suffering from a non-psychotic psychiatric disorder, people whose difficulties may be particularly likely to remain undetected in usual circumstances (Kay et al, 1964; Foster et al, 1976).

5. Conclusions

The evidence suggests that the scheme provides a setting within which good social work practice can develop, providing more efficient and effective care of a client group who were until recently relatively neglected. Through the development of the case-management role, it is possible to identify a clear structure for the social work task with frail elderly people. The move towards community-based care for other groups, such as the chronically mentally ill and the mentally handicapped, requiring long-term care makes this case-management role of wider significance. Furthermore, with the current interest in decentralisation in social services departments, the framework of the scheme offers one way in which control of resources may be devolved to the level of front-line workers in a way which enables greater autonomy to be reconciled with accountability and agency policy.

Table 1 : Outcome Over Three Years of Matched Cases

OUTCOME	YEAR 1 %		YEAR 2 %		YEAR 3 %	
	CCS	CONTROL	CCS	CONTROL	CCS	CONTROL
Own Home	69	34	50	20	35	12
Local Authority Care	4	22	5	23	8	20
Private Res. Care	8	5	15	11	14	11
Hospital Care	4	5	3	3	8	1
Died	14	33	26	40	32	53
Moved Away	1	1	1	3	3	3
N=74	100	100	100	100	100	100

Table 2 : Quality of Life Factors

	Mean Change		Significance
Variable	Community Care	Control Group	P
Morale	2.99	-1.00	<.001
Depressed Mood	-0.68	-0.17	<.05
Anxiety	-0.39	-0.2	NS
Loneliness	-1.46	0.36	<.001
Felt capacity to cope	5.03	0.66	<.001

Table 3 : Quality of Care Factors

Variable	Mean Change Community Care	 Control Group	Significance P
Need for additional help night and morning	-0.58	0.13	<.05
Need for additional help with personal care	-9.47	-1.29	<.001
Need for additional help with domestic care	-6.68	-1.71	<.001
Increase in social contact	5.66	-0.77	<.001
Need for additional services	-2.44	0.69	<.001

Table 4 : Outcomes for Principal Carers

VARIABLE	Mean Change Experimental	 Control	Significance P
1 Level of subjective Burden	-1.12	-.33	.03
2 Extent of Strain	-1.24	-.5	.09
3 Mental Health Difficulties	-.82	-.25	.09
4 Difficulties in social life	-.71	-.67	NS
5 Difficulties in household routine	-.76	-.42	NS
6 Difficulties in Employment	-.18	-.01	NS
7 financial difficulties	-.12	-.25	NS

Table 5 : Effects Upon Informal Care Over One Year

	FAMILY CARE		OTHER INFORMAL CARERS	
	Community Care Scheme %	Comparison Group %	Community Care Scheme %	Comparison Group %
Increased care	12	8	22	24
Same level of care	83	84	59	48
Reduced care	5	8	19	28

Table 6 : Costs of Matched Pairs of Cases (1977) prices)

	Annual Cost £		Cost Per Month £	
	Comm. Care	Control	Comm. Care	Control
Social Services Department	639	702	52	59
National Health Service	778	708	69	75
Society as a whole	2850	2686	238	265

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APPENDIX 2

POLICY GUIDELINES

CONTINUING CARE

PROVINCE OF MANITOBA

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I. PROGRAM PHILOSOPHY, DEFINITION, OBJECTIVES, PRINCIPLES

1. Philosophy:

Individuals progress towards and remain in a state of high level well ness in the familiar environment of their own home.

It is preferable for indivuduals to remain at home to the extent that needed resources can be made available.

Care in a facility is appropriate where resources of person, family, community and program cannot sustain an individual in the home.

2. Definitions:

CONTINUING CARE - refers to continuity in the meeting of care needs for the individual from the initial recognition of need for the individual living at home through temporary absences from home (hospitalization) and through placement into a care facility for those for whom such is required.

The Continuing Care Program, therefore, provides 1) services to support the provision of care at home (Home Care) including family relief, Respite Care and Adult Day Care and 2) assessment for placement into a care facility.

HOME CARE - may be defined as the co-ordinated delivery of a broad range of health and social services to meet the needs of the persons who require assistance or support in order to remain at home or whose functioning without Home Care is likely to deteriorate making it impossible for the person to stay at home in the community.

Upon identification of needs, services are organized in order to avoid deterioration and maintain or enhance health.*

FAMILY RELIEF is care provided at home as a Home Care Service for short periods during the week for the purpose of supporting the

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*Health is defined as the state of complete physical, mental and social well-being, not merely the absence of disease. Where "HEALTH" is used throughout these Guidelines, it will be in reference to this definition.

family environment by providing relief to family care givers to permit them time to shop, attend to business or to obtain needed rest. Such care is not available to licensed/approved family care/boarding care/Guest homes.

RESPITE CARE is care provided for weekend or extended periods for (vacation) relief for family members who regularly provide extensive care to a family member. Such care is based on a Home Care assesment and may be provided as care for the person at home as a Home Ca service or through temporary placement into a Personal Care Home or hospital providing respite care.

ADULT DAY CARE is care provided for daytime socialization and supervised recreation to persons receiving or eligible for Home Care. This care is provided through approved Adult Day Care programs in Personal Care Homes or in the community. This care also provides relief to families.

3. Objectives

1) To provide an assessment for care which determines whether a person's care needs can be met appropriately at home or whether the person requires an institutional setting to meet care needs.

2) To develop and provide services in the home setting as a viable form of care.

3) To provide services at home as an alternative to institutional care for those for whom care at home is most appropriate.

4) To facilitate placement into care facilities for those for whom care at home is not appropriate.

5) To relieve excess stress on family members and, in so doing, prevent the breakdown of a desirable living arrangement and/or the health of the person/persons providing care.

6) To prevent the premature, expensive placement or over-stay of persons in care facilities (including hospitals) and thus prevent the over-building and/or over-utilization of institutional facilities.

7) To continuously evaluate the impact of the Continuing Care program on the target population and other Health Care delivery systems.

4. Principles

1) Eligibility for Continuing Care Services is based on assessment of care needs to determine if Home Care is the most appropriate form of care or whether placement into a care facility is indicated.

2) Requests for assessment for care may come from any source in the community.

3) Home Care Services are not provided to meet care needs for which the individual has recourse to appropriate services from family, community, other government programs.

4) Home Care Services will be increased, decreased, varied or terminated as assessed care needs change.

5) Home Care Services will be provided by persons with the minimum skill required to provide the service.

6) In the delivery of Home Care, the available resources will be organized to maximize the use of services in the most cost-effective manner.

7) Placement into a care facility will first be offered to those who, with available Home Care resources in place, remain at high risk in the community and to those who are in a hospital waiting for placement.

8) In each community area, a process of interfacing with facilities and with community resources will be developed for the purpose of assuring collaborative planning and service delivery.

II. PROGRAM ADMINISTRATION

1. Central Office

The Office of Continuing Care is the established program office within the Community Health Services Division of the Department of Health responsible, province-wide, for program development, standards, coordination and evaluation of the Continuing Care Program. This Office is the single Provincial program focus for:

1) The policy Guidelines for Continuing Care.

2) Coordination of Home Care and Placement services.

3) Coordination of the Continuing Care program with other components of the Health Care system.

4) Direct and indirect funding of Home Care Services provided through regional offices, Health Centres and designated hospitals and agencies.

5) The policy Guidelines for Personal Care Home assessment and panelling and for priorization for admission to Personal Care Homes.

2. Service Delivery

The Regional Offices, designated District Health Centres and designated hsopitals/agencies, are responsible for the implementation of the program, within policy Guidelines, for a geographical area or for designated components of the program as follows:

1) Coordination of assessment for care and determination of program eligibility.

2) Coordination of care planning and of the delivery of services to individuals on the Home Care program.

3) Review and revision of client care plans and of services provided as care needs change.

4) Local development of resources required for the delivery of Home Care Services.

5) Coordination within the community for development/ utilization of community resources.

6) The panelling of cases for Personal Care Home placement (where delegated).

7) The maintenance of required program procedures and information/reporting systems.

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8) Exercising fiscal responsibility and control based on allocations made for Home Care by the Office of Continuing Care.

3. Personnel for Service Delivery

1) Implementation of the program in all its aspects is the responsibility of a Regional Continuing Care Coordinator in a regional office or a specified staff person in a designated agency. This responsibility is shared with the Regional Director/Agency and with the Office of Continuing Care in that the Regional Coordinator/staff person is operationally responsible to the Regional Director/Agency with program policy direction from the Director of Continuing Care.

2) The functions of assessment, care planning, health or social counselling, development of resources and supervision of services is done by professional staff of the region/agency.

3) Personnel for the deliverying of services in the home, except where approved as purchased services under government policy (eg. V.O.N.) will be recruited and employed by the program.

4) Personnel employed by the program will receive all benefits set out in the Employment Standards Act and such other benefits specifically approved by government.

5) Pay rates and other benefits for persons employed by the program are recommended by Personnel Services Branch and the Office of Continuing Care, approved by government. (see Continuing Care Payroll and Personnel manuals).

III. PROGRAM OPERATIONS

1. HOME CARE

1) Determining individual eligibility for Home Care:
Eligibility is determined by a total assessment of the person's ability to function in the home environment. This is a professional assessment and includes an assessment of clinical status, health functioning, social functioning and environmental support. The clinical assessment need not precede initial placement of services in urgent situations.

2) The assessment identifies:
   a) Those activities basic to household, health, personal and social needs and essential to remaining at home in the community which the person can perform and those which the person cannot, or should not, perform.
   b) Those activities which others in the household or which family members living within a reasonable distance are performing or could realistically perform.
   c) Those activities for which resources exist in the community or through other government programs.
   d) Those needs which are not being met.

3) The Office of Continuing Care may be consulted and should be made aware of specific instances where a person with unmet need does not appear to be eligible.

The Process of Assessment

1) A staff member of the department or designated agency undertakes to coordinate the assessment of needs for each person referred including consultation with family members or friends.

2) The needs of the person are identified.

3) The current and potential capabilities as well as inabilities of the individual to function are determined.

4) The person's eligibility for the Home Care Program (and/or for placement into a Personal Care Home) is established.

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5) An appropriate care plan is set up in consultation with the family, agency, and/or interested persons.

6) The appropriate assessment and other reporting forms are filled in.

7) A case record is opened and registered.

Implementation of Home Care Plan

1) The appropriate tentative Care Plan is discussed with the family, and they are informed that the plan is temporary and subject to change according to improvements and changing needs and under constant review.

2) Home Care Services are coordinated and placed if needed according to the Care Plan.

3) A Case Coordinator is identified according to the major presenting needs requiring input in the situation; this may be a shifting role as needs change.

4) It is the responsibility of the Care Coordinator to:

   i) Provide for, or coordinate the appropriate input required.
   ii) Evaluate the individual and/or family's progress on an ongoing basis and within required review limits.
   iii) Place and withdraw services as needs change.
   iv) Complete the appropriate case record reporting forms.

Needs to be met by Home Care consist of those services which can be provided to fill the gap between what the person needs and what services can be performed by the individual and family members can themselves perform.

5) Family resources are mobilized if they exist. No immediate family members are to be paid for providing care.

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6) The minimum amount of services required to meet needs are placed so as to foster as much independence on the individual and families part as possible.

7) A date for reassessment of the person's needs is set by the Case Coordinator/Team.

Case Review for Home Care

1) At the time of initial institution of the Care Plan with the individual and/or family, a date of review is set on the basis of presenting needs, and review must be carried out as initially set up.

2) The progress and/or effectiveness of the Care Plan is evaluated with the invidual and/or family and other workers involved.

3) The Care Plan is altered to meet the changed needs and progress and future plans are discussed with the individual and/or family.

4) Services are added, withdrawn, or changed according to the progress made.

2. Personal Care Home Placement

The Continuing Care program is delegated responsibility by the Manitoba Health Service Commission for assessment and panelling for placement (see Personal Care Home Administrative Manual).

Assessment for Placement Into Personal Care Homes

1) The Application/Assessment for Personal Care Home Placement provides for assessment of clinical status, nursing requirements and social requirements.
2) Wherever possible, this assessment is coordinated by the same staff person who has (or would, if indicated) coordinated assessment for Home Care to assure that the most appropriate form of care is provided and to make Home Care Service available pending placement, where needed.

Assessment Panels

The Continuing Care program is responsible for the establishment of panels, the assessment and panelling process, for priorization for placement and for maintenance of waiting lists as follows:

1) Panels will be established and held throughout the province to determine need for placement within a reasonable period of time.
2) Staff will refer to panel only those persons for whom the assessment indicates that placement in a Personal Care Home may be the most appropriate plan of action.
3) If an individual and/or family requests panelling even though the assessment indicates that Home Care is the more appropriate plan, a panel is to be held.
4) Pending panelling and/or placement, Home Care may be provided, if needed.
5) If the person or family member(s) disagree with a panel decision, the panel may be reheld with the family member(s) present.
6) A panel may be held for those on Home Care if the team members feel that a consultation is desirable to assist the Home Care Plan or if Home Care policy requires such.
7) The Case Coordinator and person/family will be informed immediately of panel decisions.

Priority for Personal Care Home Placement

1) The Office of Continuing Care establishes criteria for priorizing need for placement in consultation with the Manitoba Health Services Commission.

2) The criteria for priorizing placement will provide for movement of persons from hospital who are awaiting placement while accommodating the placement need of those on Home Care who are at high risk while in the community.
3) The determination of priority for placement in individual cases is determined by panel, subsequently delegated to program staff subject to review by panel as may be indicated.

Maintenance of Waiting List

1) Waiting lists are maintained in Regional Offices.
2) Waiting lists are managed to accommodate priority for placement and changing priority for placement.
3) Applications for placement are forwarded to the Personal Care Home of choice by priority and at the rate necessary to meet the range of care levels and vacancy rate of the home.

Reassessment for Personal Care Home Placement

Reassessment of persons on the waiting list for Personal Care Home Placement will be carried out according to requirements set by the Manitoba Health Services Commission and the Office of Continuing Care for the purpose of assuring updated assessment for placement.

3. PROGRAM REVIEW SYSTEM

The Office of Continuing Care will develop, maintain and monitor a review system for the Continuing Care program which comprises the following components:

Case Review

1) This review, as described above for Home Care and Personal Care Home Placement is a reassessment process in which the individual and/or family's needs are reassessed and changes may or may not be made in the care plan and/or in services provided and/or in priority or level of care for placement.

2) A Case Coordinator is responsible for case reviews, for determining the timing of such reviews relative to possible changing needs and for judging the extent of review required.

Caseload Review

1) These reviews assure that service is delivered within policy guidelines by focussing on caseloads, including those awaiting placement, and components of service delivery.

2) The Regional/Agency Continuing Care Coordinator is responsible for the conduct of these reviews.

3) Such reviews will be attended by the case coordinator and senior regiona/agency staff and, where possible, by staff from the Office of Continuing Care.

Program Reviews

1) These reviews assess program delivery and effectiveness in a region/agency by focussing on the extent to which program objectives are being met.

2) These reviews are conducted by the Director of Continuing Care and the Regional/Agency Director.

3) These reviews will be attended by the Regional Continuing Care Coordinator and such other regional/program/departmental staff as deemed appropriate.

III. HOME CARE SERVICES

1. Scope of Services

Services will cover a range of Health Treatment Services, Personal Care Service, Therapy Services, Home Support Services, Health Promotion Services, Social Services, Volunteer Services and Supplies as required to maintain a person in the home environment. In every instance the nature and extent of service will be provided by the person with the minimum of skill required to provide this service. For example: where the L.P.N., Homemaker Attendant has the ability to provide the services, they will be assigned to do so.

Services required within a Care Plan may include those delivered in the home as well as those utilized by persons outside the home (eg. Day Care, Respite Care).

2. Service Limits

1) The cost of Home Care Services should not exceed the cost to government of alternate placement except in specific instances outlined below or as approved as special cases by the Office of Continuing Care. This refers to the cost of direct Home Care Services, does not include service provided by regular Regional/Agency staff and does not include the cost of supplies and equipment.

2) Situations Where Service Limits May be Exceeded

   a) Where personal care home placement is the appropriate form of care and an application for placement has been made or is in process, this cost limit may be exceeded.

   b) Where the need for additional care is temporary, associated with an acute health condition or with absence/reduced capacity of usual family or other care giver, this cost limit may be exceeded.

   c) Where the need for additional care is associated with terminal illness and care can be provided appropriately at home, this cost may be exceeded.

3) Special Cases

Special Cases which do not fit 2) a), b) or c) above, where care costs would exceed service limits and where care at home may be more appropriate than placement, are to be referred to the Director of Continuing Care for decision.

4) Services can be provided only to the extent that manpower is or can be made available.

5) If the services required for Home Care are in short supply, priority is given to those persons who are most urgently in need of service.

6) Wherever possible, a person is to be taught other ways of performing a function rather than meeting need through the provision of service.

7) Where the request for any Home Care service results from the absence (temporary or otherwise) of services normally provided outside the home by another program or institution (O.P.D.) and the person would be able to utilize that service, Home Care service will not be provided except as approved by the Office of Continuing Care.

8) In the provision of services, the available manpower must be utilized in a way that will maximize the use of services in the most economic way.

   i) Where reasonable, the grouping of services delivery should be considered. (eg. Senior Citizen's Housing or apartment building - one Homemaker employed for a decided number of hours to provide services to several persons rather than employing more than one Homemaker to attend each separately).

   ii) Volunteer resources are to be recruited to complement paid services.

   iii) Hourly paid staff should be discouraged from accepting employment by the client for any more hours than recommended in the Care Plan.

IV. HOME CARE AND OTHER GOVERNMENT SERVICES

1. Child and Family Services/Mental Health Services/Mental Retardation Services

1) The Home Care program provides services to persons receiving services from these programs where Home Care assessment determines eligibility for Home Care and where the services are not provided by policy of these other programs. Where Home Care personnel may be utilized to provide service under the policy of another program, costs are charged back to the other program.

2) The Home Care program does not undertake to provide relief to "foster parents" or to operators of group homes or Guest Homes nor to provide care services to residents which are normally provided, or advertised to be provided, by the operators of these homes.

3) The Home Care program does not provide services for personal development which are within the specific policy parameters of another government program - eg. teaching parenting, infant stimulation, child development, behaviour modification, etc.

2. Social Allowance Program

1) Persons on Social Allowance when need for care arises which can be met through the Social Allowance program will be referred to the Home Care Program where the assessment and coordination provisions of the Home Care Program are required.

2) Persons admitted to Home Care will not be tested for Social Allowance eligibility. However, with persons already enrolled on Social Allowance when admitted to Home Care or who become enrolled on Social Allowance while on Home Care for needs other than Home Care needs, the costs of direct Home Care Services will be charged to the Social Allowance appropriation and be cost-shared with the Federal Government under the Canada Assistance Plan.

(2-sided copy)

Manitoba Home Care Program

Care Assessment Form

Manitoba Health

Applicant's Name	Phone No.	Date
Address	Postal Code	Home Care No.
TYPE OF ASSESSMENT ☐ Admission ☐ Reassessment		Co-ordinator
Location where assessment completed (own house, hospital, etc.)		Agency

[redacted]

1 Who lives in same household with applicant? (If none, write "none" in space.)

Name	Age	Relationship	REMARKS (Indicate if supportive of applicant and how.)

2 List relevant family members. (If none, write "none" in space.)
Please check (✓) next of Kin or local person responsible.

Please check (✓)	REMARKS (Indicate distance, frequency of contact, supportiveness of applicant and how.)
Name Address	
Name Address	
Name Address	
Name Address	

3 Any additional information/assessment re family functioning pertinent to assessment for/delivery of home care:

MG-8513

[redacted]

4 APPLICANT LIVES IN ☐ House ☐ Rooms ☐ Apartment ☐ Senior Citizen Housing ☐ Family Care/Foster Home

☐ Other (specify) REMARKS

5 INDICATE FACILITIES AVAILABLE AND ADEQUACY

	Available (type)	Adequacy (yes, no, if no explain)
HEATING		
COOKING		
REFRIGERATION		
LAUNDRY		
DRYING		
WATER		
TOILET		
BATHING		
STAIRS		
TELEPHONE		

6 Indicate if any of above facilities (including their location) affect the ability of the applicant to function in home or to get outside:

7 Indicate if any of above facilities (including their location) will affect the need for and delivery of services in the home:

8 HOUSEHOLD TASKS/MANAGEMENT	Formerly Done By Applicant Yes/No	Still Done Yes/No	REMARKS Where still done indicate any limitations, also where not done but if formerly done indicate why not done and specify who (if anyone) now does it.
LIGHT CLEANING			
HEAVY CLEANING			
PERSONAL LAUNDRY			
HOUSEHOLD LAUNDRY			
SHOPPING			
FULL MEAL PREPARATION			
LIGHT MEAL PREPARATION			
USE PHONE			
MANAGEMENT OF OWN AFFAIRS			

9 Any additional information/assessment re household functioning pertinent to the assessment for/delivery of home care:

[redacted]

10 **MAJOR CLINICAL FINDINGS**: (Do not repeat if on basic information sheet.)
Diagnosis/Extent of Disability:

Diagnosis Known:
To Family ☐ Yes ☐ No
To Applicant ☐ Yes ☐ No

11 CLINICAL HISTORY

12 ALLERGIES: if any, describe

13 Medication	Dosage	Frequency	Route	Prescribed By	Date

Ability to Administer: Independent ☐ Requires Assistance ☐ Specify

Compliance:

14 Current prescribed treatments, if any: Indicate applicant's ability to manage own treatment.
Independent ☐ Requires Assistance ☐ Specify

15 Have clinical findings/treatment been confirmed with attending physician? ☐ Yes ☐ No
If Yes, how. If No, what is
the plan for confirmation?

16 NUTRITION: Is applicant eating adequately: ☐ Yes ☐ No Is applicant on special diet? ☐ Yes ☐ No
COMMENTS:

17 Any additional information/assessment re physical health functioning pertinent to the assessment for/delivery of home care:

[redacted]

REMARKS Should reveal any patterns/inconsistencies,
Should include any current or planned treatment/intervention,
Should cover implications for self care, for socialization

18 SIGHT

Wears glasses ☐ Yes ☐ No

____ Adequate for all activities

____ Inadequate for some activities (specify)

____ Inadequate for personal safety (specify)

REMARKS:

19 HEARING

Wears hearing aid ☐ Yes ☐ No

____ Adequate for all activities

____ Inadequate for some activities (specify)

____ Inadequate for personal safety (specify)

20 COMMUNICATION

____ Gestures only ____ Written only

____ Adequate for all activities
____ Inadequate for some activities (specify)
____ Unable to communicate

21 AMBULATION
____ Independent with or without mech aid
____ Outdoors with assistance
____ Indoors amb with assistance
____ Stairs with assistance
____ Stairs independent
____ Cannot manage stairs
____ Wheelchair independent
____ Wheelchair with assistance

22 TOILETING

CONTINENCE

____ Completely continent
____ Incontinent urine, occasionally
____ Incontinent urine, night only
____ Incontinent urine, always
____ Incontinent feces, occasionally
____ Incontinent feces, always

MANAGEMENT

____ Independent
____ Dependent (elaborate)
☐ Catheter
☐ Ostomy
☐ Condom Drainage
☐ Bathroom Routine
☐ Other Aids

23 **TRANSFERRING:** **REMARKS:**

___ **Independent**

___ **Bed to chair with assistance**

___ **Bedfast, can turn self in bed**

___ **Bedfast, must be turned in bed**

24 EATING:

Dentures: ☐ Upper ☐ Lower

___ Independent

___ Requires assistance or encouragement

___ Has to be fed

25 DRESSING:

___ Independent

___ Requires assistance or encouragement

___ Has to be dressed/undressed

26 BATHING:

___ Independent

___ Can sponge bath self

___ Can bath only with assistance or encouragement

___ Has to be bathed

27 CARE OF HAIR:

___ Independent

___ Requires assistance or encouragement

___ Cannot care for own hair

28 FOOT CARE

___ Independent ___ Cannot care for own feet

___ Requires Assistance

29 CARE FOR PROTHESIS:

Where applicable, indicate type of prothesis and ability of applicant to care for such.

Any additional information/assessment re personal care functioning pertinent to the assessment for/delivery of home care:

[redacted]

30 Has applicant's living pattern/role in family or household altered in past year? Describe showing whether there has been change or loss and indicate whether (how) applicant is coping. Look for indicators of loneliness, bereavement or loss of status.

31 Describe how applicant spends his/her time in a typical day at home and indicate if applicant describes his/her activities as being meaningful to others, to self or simply as a means of passing time.

32 Are there any activities which the applicant formerly was engaged in at home which he/she now misses? Why? Could the applicant be involved again in the same or similar activity with assistance/intervention? What?

33 Neighbours, friends in contact with applicant		REMARKS: (Indicate frequency of contact and supportiveness to applicant and in what way.)
Name	Phone #	
Address		
Name	Phone #	
Address		
Name	Phone #	
Address		
Name	Phone #	
Address		

34 Describe applicant's involvement in community (include church, legion, fraternal, etc.)

35 Are there any community activities in which the applicant formerly was involved which he/she now misses? Could the applicant be involved again with assistance/intervention? What?

36 **Does travel outside the home affect applicant's ability to participate in activities, to receive medical care, to manage the household, etc.? If so, describe why, how and intervention indicated.**

37 **Specify cultural/religious preferences of applicant relevant to delivery of home care services (language, special food, etc.)**

REMARKS: Should reveal any patterns/inconsistencies,
Should include any current or planned treatment/intervention;
Should cover implications for self care, for socialization.

38 **MENTAL STATUS:**

REMARKS:

____ Completely oriented

____ Forgetful/confused occ.

____ Disoriented

39 **MOOD:**

____ Seems content

____ Seems concerned about specific problem

____ Seems somewhat tense and anxious

____ Seems depressed

____ Unusual, unpredictable behavior (specify)

____ Not motivated for some activities (specify)

40 **MOTIVATION:**

____ Motivated for all activities

____ Not motivated for some activies (specify)

____ Not motivated for most activities

41 **JUDGEMENT IN PRESENT SITUATION:**

____ Realistic

____ Adequate for personal safety

____ Limited ability to make judgements

____ Unrealistic

42 **Any additional information/assessment re psycho/social functioning pertinent to assessment for/delivery of home care:**

SUMMARY ASSESSMENT

Under the following headings indicate the area(s) (if any) where the applicant cannot meet need through self-functioning or through the services of available family or others, and which, if the need is not met, places the applicant at risk of not being able to remain in the community-or-places the applicant at risk of deterioration which could directly contribute toward inability to remain in the community.

Where the applicant's ability to remain in the community is dependent upon the service of others in the household or in the community, show where the relief of such providers is realistically indicated for continued living in the community.

HOUSEHOLD MAINTENANCE NEEDS

HEALTH NEEDS

PERSONAL CARE NEEDS

PSYCHO/SOCIAL NEEDS

SUPPLIES/EQUIPMENT NEEDS

Manitoba Home Care Program

Manitoba
Health

HOME CARE SHORT TERM ASSESSMENT/HOSPITAL DISCHARGE FORM
and BASIC INFORMATION FORM

Proceed with Admission to Home Care ____________

Date Services to Begin ____________

Other Actions ________ (Indicate) ________

Health and Community Services/Agency Care Co-ordinator

Home Care Number

Name of Co-ordinator

Date of Referral Day Month Year

Co-ordinating Agency/Area

☐ new ☐ resume ☐ reopened

Agency to be Billed

Client's Name (Surname) (Given Names)

Sex

Birthdate Day Month Year

Phone Number

Home Address P.O. Box No

Street Address

Postal Code

Band Name

Treaty Number

M.H.S.C. No

Social Insurance No.

Region

Area

Can Person Communicate in English?

In Which Language Does Person Communicate Best?

Present Location: ☐ Same as Address ☐ Hospital ☐ Hostel ☐ Nursing Home ☐ Home of Relative ☐ Room and Board/Foster Home ☐ Other (specify)

Present Address

Postal Code

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced/Separated ☐ Other

Next of Kin or Person Responsible – Name

Relationship

Phone Number

Address

Postal Code

Next of Kin or Person Responsible – Name

Relationship

Phone Number

Address

Postal Code

Person Making Referral:

Relationship/Agency

Phone Number

Address

Postal Code

Physician's Name

Address

Phone Number

Physician's Name

Address

Phone Number

Physician's Name

Address

Phone Number

Surgical Procedures and Date

Hospital Admission Date ____________

Diagnosis: /Extent of Disability

Discharge Date ____________

Diagnosis Known:

To Family	**To Person**
☐ Yes	☐ Yes
☐ No	☐ No

Prognosis:

☐ A Rehabilitation

☐ B Maintenance at Present

☐ C Deterioration Likely

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Client's Name ____________________
(Surname) (Given Names)

Discharge Medications/Treatment:

Diet:

Living Arrangement:
- ______ Alone
- ______ With Relatives
- ______ With Others

Family Support:
- ______ Not Available
- ______ Minimal
- ______ Moderate
- ______ Complete

Daily Living:

Is patient/or other family members able to
Prepare meals yes ____ no ____
Do the shopping yes ____ no ____
Do the housekeeping yes ____ no ____
Arrange own satisfying activities yes ____ no ____

Environment:
- ______ Satisfactory
- ______ Unsatisfactory (explain)

Comments:

Other Agency Involvement: Agency

Services Provided:

1 AMBULATION

- ______ Unlimited cor s mech aid
- ______ Outdoors with aid
- ______ Indoors, semi-amb
- ______ Indoors, semi-amb with aid
- ______ Wheelchair independent
- ______ Wheelchair with aid
- ______ Bed to chair
- ______ Bed to chair with aid
- ______ Bedfast – can turn self
- ______ Bedfast – must be turned
- ______ Other

2 CONTINENCE

- ______ Completely continent
- ______ Incontinent urine, occ
- ______ Incontinent urine, always
- ______ Indwelling catheter
- ______ Incontinent feces, occ
- ______ Incontinent feces, always
- ______ Colostomy
- ______ Other

3 MENTAL STATUS

- ______ Completely oriented
- ______ Mildly confused, occ
- ______ Mildly confused, always
- ______ Moderately confused, occ
- ______ Moderately confused, always
- ______ Markedly confused, occ
- ______ Markedly confused, always
- ______ Depressed
- ______ Overly anxious
- ______ Bizarre behaviour
- ______ Other

4 PERSONAL CARE ASSISTANCE

Bathing	Dressing	Toileting	Feeding	
				– No help needed
				– Minimal help
				– Moderate help
				– Complete help

Services Recommended: **Nature/type of service** **Amount and Frequency:**

______ Nursing ____________________
______ Therapy ☐ pt ☐ ot ____________________
______ Home Care Attendant/Orderly ____________________
______ Homemaking ____________________
______ Day Hospital ____________________
______ Meal Delivery ____________________
______ Adult Day Care ____________________
______ Other (specify) ____________________

Supplies and/or Equipment Requested: ____________________

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Continuing Care Program

Home Care and/or Assessment for Personal Care Home Placement

Region/Office ______________ Area ______________ Month ______________

Table #1 Continuing Care Case Count*	Age			Total
	0 – 18	19 – 64	65+	
Case Records Open Beginning of Month				
Case Records Opened/Reopened During Month				
Transferred In				
Total Intake				
Total Case Records for Month				
Case Records Closed During Month				
Transferred Out				
Total Outgo				
Case Records Continuing Open at End of Month				

*Do not count cases carried on a request basis for other region/agency. This would be shown on Table No. 9.

Table #2 Home Care Service Count by Age Breakdown	Age			Total
	0 – 18	19 – 64	65+	
Persons Receiving Home Care Service at Beginning of Month				
Intake: Persons Admitted to Home Care Service				
Persons Re-admitted to Home Care Service				
Transferred In				
Total Intake				
Total for Month				
Outgo: Persons Discharged from Home Care Service				
Transferred Out				
Total Outgo				
Number of Persons Receiving Service at End of Month				

Definitions:

Admission	– A person who, following assessment, is admitted to receive Home Care Service.
Re-Admission	– A person who, is re-admitted to receive Home Care Services following a previous admission and discharge.
Discharge	– A person where all components of Home Care Services have been terminated and are likely to remain terminated for more than three weeks.

MG-8947

Home Care Resource Utilization

Manitoba
Health

Table #3

Region/Agency ____________________ Area ____________________ Month: ________

	Services Provided		Number of Persons Receiving Service in the Month	Number of Persons Providing Service in the Month	Units of Service Provided in the Month
Direct Services	**Homemaking:**	– Homemaker Payroll			
		– Victorian Order of Nurses, hm			
		– Other (Specify)			
	Attendant Services:	– Home Care Attendants' Payroll			
		– M.H.S. Orderly Services			
		– Purchased P.C. Attendant Services			
	Nursing:	– R.N.'s Homemaker Payroll			
		– R.N.'s Term Payroll			
		– Victorian Order of Nurses			
		– L.P.N.'s Homemaker Payroll			
		– L.P.N.'s Term Payroll			
	Therapy:	– Community Therapy Services			
		– Other (Specify)			
Request Services					
In Home Respite					
Training					
Indirect Services	Homemaker Coordination (Homemaker Payroll)				
	Homemaker Coordination (Term)				
	Nursing Coordination (Homemaker Payroll)				
	Nursing Coordination (Term)				
	Other (Specify)				

MG 12333

Home Care Statistics

Manitoba
Health

Region/Office ______________________ Area ______________________ Month ________

Table 4	Source of Referral						
Number Admitted to Home	Self	Doctor	Hospital	Family/ Friend	Other Agency	Own Agency	Total
Care During Month							

Table 5	Care Level Equivalent at Point of Admission/Re-admission							
Number Admitted to Home	Personal Care Home Level I	Personal Care Home Level II	Personal Care Home Levels III/IV	Hospital Acute Care Level	Hospital Extended Care Level	Other Facility	No Facility Care Level Equivalent	Total
Care During Month								

Table 6	Non-Admission Disposition						
Number Assessed But Not	Home Care Services Not Required	Person or Family Refused	Admitted to Care Facility or Hospital	Home Not Suitable For Home Care	Person Deceased	Other	Total
Admitted to Program							

Table 7	Discharge Disposition						
Number Discharged From	Hospital Admission Including Extended Care Hospital	Personal Care Home Placement	Person Deceased	Care No Longer Required		Other	Total
				Service Provided By Other	Improved Recovered		
Home Care During Month							

Definitions:

Number Admitted to Home Care During Month — Admissions and Re-admissions to Home Care during month. (Not transfers in)

Source of Referral — Information from Section 4, Case Action Form

— own agency internal Continuing Care — other agency — external to the Program

Care Level Equivalant — from Section 5, Case Action Form.

Number Assessed But Not Admitted to Program — Includes cases assessed but not admitted to program. (Section 2)

Non-Admission Dispositions — Other — Includes those where family made own plans.

Number Discharged From Home Care During Month — from Section 6, Case Action Form. Does not include transfers out.

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Assessment for Personal Care Home Placement

Region/Office: ______________________ Area: ______________________ Month: ____________

Table 8: Panel Recommendations for Persons Assessed for Personal Care Home Placement

	Regional Cases Panelled in the Month			Inter-Regional Placement Requests Panelled	Personal Care Home Transfer Requests Panelled
	Community	Hospital	Total		
Hostel (Level I)					
Personal Care (Level II)					
Extended Care (Levels III & IV)					
Total for Placement					
Hospital Care/Extended Care	▨	▨			
Home Care Only	▨	▨			
Placement/Home Care not required	▨	▨			
Deferred	▨	▨			
Other	▨	▨			
Total Cases Panelled	▨	▨			

Total panelled in the month who will be on Home Care Pending Placement ______________

Table 9: Number of Persons on Waiting List by Level and Category

	Level and Category						Total	Inter-Regional Placement Requests	Personal Care Home Transfer Requests
	Hostel, Level I		Personal Care Level II		Extended Care Levels III & IV				
	Community	Hospital	Community	Hospital	Community	Hospital			
Number of Persons on Waiting List, Beginning of Month									
Persons Added to Waiting List During Month									
Reclassified In								▨	▨
Total on Waiting List for Month									
Persons Placed or Removed from List During Month									
Reclassified Out								▨	▨
Persons on Waiting List End of Month									

Reclassified — Indicate change from one level or category to another
Reclassified in and out should balance
Hospital — Persons in hospital who are not returning to the community and are waiting placement.
Community — All other cases are community cases.
Placement Request — Category for persons who have been panelled in another region and who are waiting placement in this region.
Placement Request and Inter-Personal Care Home Transfers are not included in the Total.

MG-8856

Abstracted from:

"BOUNDARY CROSSING: AN ORGANIZATIONAL CHALLENGE FOR COMMUNITY-BASED LONG-TERM SERVICE AGENCIES"

by Betty Havens

Traditionally, the typical long-term care response from the health service sector is based on institutionalization of "patients". On the other hand, the long-term care response from the social service sector is based on subsidizing "recipients". In this milieu, maverick community-based long-term care programs typically respond by coordinating services based on the assessed needs of a "client" or "resident".

Community-based long-term care programs are located within, responsible to, funded by or through: the health sector in some jurisdictions; the social service sector in other jurisdictions; and, both of these sectors in still other jurisdictions. This lack of uniformity is, in some cases, initiated by programs themselves and in other cases imposed on programs by traditional health and social service systems in host jurisdictions. In either case, the result adds to confusion and highlights a view that these programs are mavericks within a single jurisdiction and across jurisdictions.

Consequently, community-based long-term care programs do not "fit" neatly in either health or social service systems, nor do they "fit" well in an overarching health and social service system. Because of variability across programs, elements that are central to one program may be peripheral to another. Further, program elements which must be negotiated across a program boundary with other health or social service programs by one community-based program are integral to another program and totally outside the parameters of a third program.

MANITOBA'S CONTINUING CARE PROGRAM

The Manitoba program is a province-wide, universal, no cost to consumer program which was initiated by the provincial government in 1974 and gradually expanded throughout the province by 1975. This program assesses persons requiring care whether for placement in nursing homes or for home care. The program delivers services to those who remain at home. The program is a coordinated service program which provides a broad range of services to meet the needs of persons who require assistance or support to remain at home or whose functioning without home care is likely to deteriorate making it impossible for the person to stay at home in the community. Upon identification of needs, services are organized to avoid deterioration and to maintain and enhance health. This is accomplished within established policy guidelines and through existing departmental health and social service/health centre network and in conjunction with relevant private voluntary agencies.

This program is delivered through regional offices and sub-offices and through health centres and private agencies identified within the program service delivery framework as coordinating agencies. These coordinating agencies are responsible for participating with the central program office in coordinated program planning and development and for providing coordinated quality service delivery within program guidelines.

Service delivery frameworks are based upon professionally coordinated and conducted assessments of need, care planning, and supervision of service delivery. Ongoing services provided in the home are delivered both by professionally skilled and paraprofessionally skilled persons.

For those of any age who are referred from any source, determination of need for service is based on a clinical, a health functioning, and a social functioning assessment. Assessment is focused to identify those who, without services, would be at risk of being able to remain at home but who, with home-delivered services, could have their care needs managed appropriately.

This program model calls for each referred person to be served primarily by one staff person called the case coordinator and for assessment and care planning to be multidisciplinary.

Program guidelines call for each person to be fully assessed including identification of those activities which the person can perform, those which family members, friends, or neighbors can realistically perform, and those which require placement of services. A care plan is developed to provide for needed services which exist within the program. When needed services are not available within the program, every effort is made to secure such services from other community sources, as part of the care plan. Services provided by the program are to be the minimum required to meet need and to foster independence. Delivery is to be organized so that services are provided by the person with the minimum skill required to perform the task.

Throughout the province, the program utilizes professional and non-professional skills including those of nurses, social workers, licensed practical nurses, aides, orderlies, therapists, home attendants, home helpers and personal care homemakers, volunteers, and the staff of voluntary agencies as well as civil servants and hourly paid casual employees.

ASSESSMENT AS A VEHICLE FOR COORDINATION AND SYSTEM CHANGE

Seldom does a client need a single service to remain in their own home in the community, so coordination of services becomes a major concern of both a providing agency and the client. If the community-based long-term care program does not include service coordination in its functions, clients or their family are left with the time and energy consuming task of trying to coordinate a variety of service deliverers. All of these providers are employed by and responsible to a variety of organizations. For the community-based program to coordinate health and social services from a variety of public, private, and voluntary agencies with those tasks performed by the client and his/her family, friends, and neighbors, a comprehensive multidimensional assessment is essential.

Common Assessment Across Social and Health Systems

Health and social service systems vary across jurisdictions. However, given the nature of community-based long-term care programs, it is likely that components of both of these systems will be integral to any specific program and other components will remain external to these programs. Establishment of an assessment process which can be used within the program itself and with components of both systems is an essential ingredient for success.

Assessment Based on Client and Informal Network Strengths and Weaknesses

Assessments for long-term care normally concentrate on client weaknesses and functional deficits. However, by operating in the community from a premise of maintaining independence, assessments are more appropriately focused on strengths of the client and his/her informal support network. The ability of an assessment to identify the strengths initially and then to proceed to identifying weaknesses which inhibit independence, allows the assessment team to develop a care plan and assign a case coordinator which will provide only those services which fill gaps in supporting a client's independence.

While it is essential to maintain independent functioning of the client and the support network, clearly, without these essential gap-filling services which respond to and compensate for weaknesses in a given situation, the whole situation can fall apart. When cases fall apart, no matter how small or simple the missing service is, the typical response is to seek placement in a nursing home. In most instances, the client and his or her support network can cope with an occasional gap in services or slowness in placing or replacing in-home services. But, repeated occurrences generally discourage the client, frustrate their support network, put undue burden on other formal caregivers/service deliverers and case coordinators, and may ultimately become an incentive to premature nursing home placement.

Final Assessment Process Decision: Site of Care

When a common assessment process is used across all sectors of long-term care and when the assessment itself is designed to establish types and amounts of care required, the last step in the process is to determine the most appropriate location for care. That is, only after all strengths and weaknesses of the client and the informal support network have been adequately assessed does the assessor begin to consider the site of care.

In addition to the "total" solution of nursing home placement and the "minimum" solution of care in one's own home there are many other potential sites of care which should be considered as options in making a final assessment decision. These include having family member(s) move into the home of the potential long-term care client, or enabling the potential client to move into the home of a family member. In some cases home sharing by unrelated individuals may also provide similar options to those involving family members. This solution is still chosen relatively infrequently among potential clients. However, as families become even more mobile and as more older adults know others who have successfully shared homes with non-family adults, this option may become more popular.

In some communities, it is possible to find a family which is willing to provide an adult foster home. These placements are more common than home sharing and have been especially successful and appropriate with mentally retarded and postmentally ill older adults. In many cases a family will foster two or even three older adults. Group homes may be an option in some jurisdictions. These placements generally include physically disabled older adults who have been disabled for many years. A typical group home provides a living arrangement for five to eight adults with a live-in caregiver or couple.

Senior citizens housing projects provide another potential site providing support services. Any person living in a senior citizen's apartment may be receiving in-home services individually just like anyone else in the community. However, the presence of several persons requiring care in a single seniors complex may lead to aggregating services in ways that are not possible with the same number of people scattered in their own homes in the community. Seniors' housing projects may provide another option in making a decision about the site of long-term care.

New options are developed all the time such as care cooperatives, board and care homes, and domiciliaries. Consequently, long-term care assessment staff and case coordinators must keep up to date on new developments and options in their own communities, to provide the broadest possible range of options to each potential client at the final stage of determining site of care.

CROSSING COUNDARIES LEADING TO INDEPENDENCE

Maintaining the balance between supporting independence without incurring dependence is critical and seldom easy to accomplish. In one example, if the case coordinator had not been committed to maintaining and supporting independence, a typical client would likely have been placed in a nursing home at the request of his niece. The innovation of the case coordinator in assisting this client in modernizing his house, not only allowed him to remain at home, but in fact, even made it unnecessary for home care services to be provided in his home. This solution has enabled him to maintain his home, his health and his independence.

Similarly in another case, providing holiday relief for a client's daughter required the case coordinator to develop innovative strategies. Not only was it necessary to cross the boundaries of a voluntary agency with a request, it was necessary for the client to become a substitute friendly visitor while the usual friendly visitor became a volunteer shopper for the single occasion required to keep this case intact.

The referral of a third client to the geriatric day hospital program for a geriatric clinical assessment provides another example of innovative system boundary crossing. The home care nurse assessor consulted with this client's family physician to arrange the referral to the geriatrician at the day hospital. The clinical assessment findings will be provided to the family physician and to the home care team should follow-up services be required. In the meantime, the client will remain at home and will continue to babysit for her great-grandchildren while she is being assessed at the day hospital. Consequently, she will be retaining her independence and continuing to contribute to her family's well-being.

In each of these examples the actual services provided may seem small and, to some, may even seem inconsequential. However, each service made the difference between independence and dependence. Each situation required the case coordinator to find innovative solutions to deliver services, each involved crossing system boundaries, and one even involved crossing jurisdictional boundaries. It should be noted, as well, that while the time and energy expended by the case coordinators may have seemed excessive two factors must be considered in this context. First, these cases remained intact and the clients and their support networks were able to remain independent. Second, neither clients nor families were required to expend already limited energies in trying to coordinate services or create innovative solutions across the multiple boundaries involved. Furthermore, if it is difficult for those who know the system to make it work, it can be virtually impossible for those who do not know the system to function within it, let alone successfully cross boundaries.

BOUNDARY CROSSING VENTURES

As has been suggested throughout the preceding, crossing boundaries is part of the stock-in-trade of community-based long-term care programs. Without a willingness to venture into boundary crossing, programs will become restrictive and boundaries will become rigid and impermeable precluding innovative individual solutions. However, negotiating the crossing of boundaries is not easy and tends to be both time and energy consuming.

There is a certain satisfaction for a professional in successfully resolving a problem with an individual client and his/her support network. This is true when a solution is relatively straightforward and all components of the solution are readily available and internal to the program. However, it is even more challenging and satisfying when the components of the solution are external to the program. One of the components which can help many families continue to maintain care with minimal formal service supports is respite care. Respite care allows the primary caregiver(s) to do things that they must do such as banking or shopping, and other things that they wish to do such as attending club meetings, joining friends for lunch, or taking a necessary vacation. Respite care may be provided in the client's home in a nearby nursing home, or in a hospital.

The difference between "holding cases together" and having them "fall apart" is being able to respond quickly to changing needs and situations. Having flexible hours of service in a community-based long-term care program can make the difference in what responses are possible. In other words, being able to adjust the hours of service to a client (or clients) depends to a large extent on the case coordinator's ability to redesign care plans quickly and on her/his ability to hire staff on an hourly basis. Staff hours will therefore vary depending on the mix of cases in a community at any given time. This variation and flexibility also requires negotiating across boundaries in terms of personnel officers, unions, labour law review boards, and payroll staff.

BENEFITS OF BOUNDARY CROSSING

A client stands to gain most when the program staff, especially the case coordinators, are not only willing to cross program and system boundaries but are also successful in doing so. It is important to the client for the program to keep its boundaries as open as possible to enable boundary crossing to occur with relative ease.

It is also advantageous for the program to be adept at crossing these boundaries. In many ways, the success of any community-based program is the sum of its successful client solutions. Successful solutions are enabled by the openness of boundaries and hence the program is more successful, too. It should also be noted explicitly, at this point, that success breeds further success. Each successful solution sets the stage for future successes.

Further, initiatives taken to meet emerging needs and which involve the crossing of boundaries, may lead to mutual recognition of these needs on both sides of the boundary and ultimately to new formal resource development. Examples of this evolution are found in the Manitoba development of adult day care programs and respite care programs in nursing homes. Formal programs began in 1979 and 1980, respectively, with entry through the program. These two new programs had their beginnings in ad hoc arrangements initiated for individual cases.

The broader community and relevant health and social service systems also benefit because they are more able to draw on resources and expertise of the long-term care program when boundaries are kept relatively open and can be relatively readily crossed. As long as the long-term care program negotiates to cross the others' boundaries, it also simultaneously becomes a resource to the other programs and systems and shares its expertise in the process. A functional reciprocity is established. An effective community-based long-term care program can enable other facets of these broader systems to function more appropriately and effectively. They will not be expected nor required to respond to inappropriate cases and situations once their internal capabilities are known by others.

CONCLUSIONS

The key to currently successful community-based long-term care programs, regardless of jurisdictional location and system descriptions, is successful boundary crossing based on common assessments, openness of boundaries, and willingness of program staff to create innovative individual case solutions. It is taken as fact that these programs are "mavericks" within health and social systems. It must also be expected that program staff will be committed to unique solutions and flexibility in use of direct service and other resources. Further, it is assumed that programs are based on maintaining independence of clients and their informal support networks while providing service to fill gaps without incurring dependence on formal system programs. Examples cited here are derived from the Continuing Care Program in Manitoba. Many components discussed here will be similar in other programs, but boundaries may be described differently in other programs requiring different boundary negotiations. In fact, the boundary descriptions have changed in Manitoba over the decade of the program's existence.

Successful programs have a higher ratio of holding cases together than watching them fall apart. A greater proportion of cases will be viewed as satisfying challenges by program staff than as frustrating time and energy consumers. Client service needs will more often be able to be met regardless of whether required services are internal to the program or across program or system boundaries. Relationships of functional reciprocity between programs will be established.

Emerging Long-Term Care Systems

One of the challenges to current program planners is to speculate as accurately as possible on what community-based long-term care programs will look like in the months and years to come. The Manitoba program has experienced changes over time and expects to continue to change as it remains responsive to changing needs of clients, their informal support networks and broader community.

Missing services or components of service identified by the program have become less frequent over the decade of the program and further resource development continues throughout the province. An imperative feature in responding to changing needs is to assure sufficient flexibility of direct service staffing and to maintain adequate program staff (case coordinators, resource developers, and administrative support personnel). Concomitantly, caseloads must be kept at a reasonable size to assure thorough and prompt assessments, regular case reviews, and appropriate reassessments. Also, as more sites for care evolve, community-based long-term care programs will have to be responsive to changing configurations of services necessary to support client independence in these newer settings.

Boundary Issues of the Future

In the milieu of fiscal responsibility and economic constraint, responsiveness to changing client needs will have to be accomplished through redirection of existing resources. This redirection will come either within these programs or across boundaries within the broader social and health systems. Under these circumstances, boundary negotiations will become even more crucial. In part, because of this anticipation of both more negotiating and more necessary innovative boundary crossing, it will become even more essential to assure adequate program staffing and to maintain sufficient direct service staffing flexibility. If the Manitoba Continuing Care Program has learned one thing through painful experience, it is that there are no savings from curtailing program staffing. Unrealistically large caseloads inhibit prompt assessments, slow down case reviews, mitigate against appropriate and timely reassessments, and preclude innovative solutions at program boundaries. They incur either client dependence through delays in withdrawing unneeded services or increased costs by employing easy solutions. This often means providing more clostly services that are integral to the program even if personnel are overskilled for requisite tasks.

In summary, boundaries will likely change over time as will client needs and community resources. However, boundary crossing will remain essential to community-based long-term care programs. Sensitivity to changing boundary descriptions, changing potential client needs and characteristics, awareness of new locally acceptable and available sites for care, and sensitivity to evolving potential resource solutions and financial trade-offs will become even more eseential for program staff. Simultaneously important will be trade-offs to the clients, the programs, the broader social and health system, and to the community at large. We would hope, that in most cases, these greater expectations of staff will provide professionally satisfying challenges rather than energy consuming frustrations.

In any case, we are assured that effective boundary crossing and innovative individualized solutions under changing circumstances with responsible fiscal limitations will be even more time and energy consuming in the future. Program staffing patterns must be adequate to this challenge or the "institutionally" easy and more costly decisions will prevail. The challenges to community-based long-term care programs will be to assure program integrity, boundary openness, staff morale, and fiscal responsibility in the face of changing clients, changing program boundaries, changing systems, and changing personnel.

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"A Long-Term Care System:
A Canadian Perspective
by
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There are differences between the United States and Canada, but I think the similarities far outweigh the differences in our two systems, our two cultures and our two countries. It is an unusual situation to have a Canadian asked to talk about Canada, particularly outside of Canada. It is a rather unique experience for me to which I bring a different perspective. I hope that we will all benefit from the combination.

One thing I would like to note is something that Dr. Kane mentioned concerning the change occurring in the distribution of beds within the personal care or nursing homes in Manitoba. You can begin to see a change in Level I, (i.e., minimum care up to 20 minutes of Nursing Service per day, largely supervision) that is a decrease in the Level I capacity being utilized in 1980. In fact that trend has continued. Further as a policy decision, as the old facilities which were built to accommodate Level I only, become obsolete (or time expired), they are being replaced with multi-level facilities so that the total quantity of Level I beds is diminishing. The demand for Level I beds is substantially less. If you happen to be a male and need Level I care in the Province of Manitoba, I can assure you that you can be in an appropriate facility within twenty-four hours. If you happen to be female and Level I care is required, it might take a week or two. If you are male and require Level II care (care of 20-45 minutes of Nursing Services per day), it may take about a week to find a suitable placement. However, if you are female and require Level II care, it may take as long as three months or sometimes more to be placed. Therefore, it is obvious that there is a very great difference in terms of distribution of the available care facilities or care locations according to both the sex and level of care of the client. But, there is also a diminishing demand for Level I institutional care. That is, the trend that was just beginning to show in the Kanes' study in 1980 has continued and is quite noticeable. This is true in terms of demand for that particular type of care and also in terms of the change in policy.

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I would also like to comment on the difference between the nursing home and home care utilization crossover at age 85, in British Columbia. This particular phenomenon applies virtually across the entire country, and results largely from the substantial decrease in informal support systems availability to those people who are over 85. That is, where home care may have been a very viable decision for those people under 85, it becomes less viable over 85 if the support systems are not able to continue to cope or are simply not available. As part of this issue a further explanation may be useful. I say that because one of the questions that I am frequently asked, when I am in the United states, is "how do we know that families won't just dump their family member into home care? How can we be sure they won't dump him or her into insured nursing homes?" In other words, in the U.S., you want families to continue caring for their older people, regardless of the relationship.

I consider home care as the most enabling of programs to insure that families can and will continue to care for older family members, and the universality of home care and insured nursing home care is a further guarantee of support by families, not a deterrent. In Manitoba, 80 percent of the care provided to people over 65 is still maintained by the family and/or by other members of the informal support system. This rate was 80 percent before home care was introduced; it was 80 percent before the insured nursing home program was introduced, and it is still 80 percent. This rate is 80 percent in three additional Canadian provinces, including two that were not included in the Kane Report. The 80 percent level is a fairly constant level. Virtually all of the literature in the United States and Europe also indicates that 80 percent of the care is provided informally. This is not a new piece of information, but it is an issue which is constantly raised as something that it is feared will change when alterations are made to insure nursing homes or long-term care. This fear is particularly common if one dares to create community-based programs to provide home care. It is feared that all families would just desert their elders; "they would just jump ship". This has not been Manitoba's experience at all. As a matter of fact, there are many elders whom one would not believe are being maintained in the community.

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Two of the most widely used program components are the adult day care program and the respite program. With these programs, families continue to cope -- whether they be spouses or siblings or children is immaterial -- with their elderly relative. Neighbors continue to cope in situations that most nursing homes look at in absolute amazement. Nursing homes cannot believe there are families and neigbors in the community coping with such heavy care. The often quoted Barbara Felton stated that "There are two to three in the community for each one in a nursing home who are in an equally debilitated state". This is certainly evident in Canada. We have long-term care, both in the institutional sector and in the community sector, and we have been able to observe that this formal care has supported the informal care system, not detracted from it.

I should point out one word which we use differently. Manitoba has always called its program the Continuing Care Program and has referred to its professional staff in the field as Continuing Care Coordinators. We talk about staff as case coordinators rather than case managers. Although other terms are used, with the possible exception of the Vancouver area, none of the Canadian programs use the term case manager. I want to dwell on this difference because I think it is very relevant to the Manitoba system and also addresses the issue of the differences between the social philosophies of Canada and of the United States.

It is the belief of the Continuing Care Program of Manitoba that one coordinates services, but one manages clients. We believe that clients can manage themselves, if given the support through coordinated services. This means the clients do not have to spend their diminished energies and time in maintaining and coordinating a system outside, made up of the professional and informal support system network. Thus, we have made a very deliberate choice in referring to our staff as coordinators. The coordination of services is so time and energy consumptive that it is often, not just occasionally, but often "the straw that breaks the client's back", or that of the client's family.

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Canadians are not eager to manage clients as in the case of the service industry. This was noted earlier in reference to the issue of litigation. The fear that we might establish management as a separate professional stream is, I hope, unfounded. Management is simply a function within the professional's role to coordinate services. I think the whole difference in approach comes through in these two terms. However, at the operational level, it is the saving of the time and energy of the individual client and/or of the families in arranging these services for the client. In other words, the case coordinator is responsible for coordinating the formal and the informal systems and all the necessary services as they apply to that individual. I think this is reflective of an important difference in operation, in approach and in philosophy.

The Continuing Care Program requires that when nursing home placement requested, the indvidual must be assessed and we prefer that assessment to be a multi-disciplinary effort, and hence, use a panel as part of the process. This panelling approach was part of the original system design, because we wanted to ensure that when the individual is assessed, that the assessment was to be only for care. Only after the individual's care needs have been assessed and the level of care determined, should one even begin to consider the site of care. In other words, the last decision to be made must be site, or location, i.e., the nursing home, the hospital, the chronic facility, the mental health institution, the foster home, the day care program, in-home, i.e., own-home, family member's home, children's homes, and all the other variations possible. In any case, the decision about location must be made last. If the location decision is made first, it begins to drive the whole system. What one needs to know is not whether or not the individual is eligible for nursing home care, although that is usually argued, but whether or not the individual needs a level of care equivalent to nursing home care, regardless of its source. Then you need to look at the potential sites at which this care can be provided and make the location decisions. They are different decisions, that is, the assessed need and level of care decision is different from the location or site of care decision.

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I would also like to point out that where the savings have come in Manitoba, where they came from in British Columbia, and have come from in those regions of Ontario that have had home care for the longest periods of time, has in fact, not been in the other long-term care programs. In other words, not in nursing homes, or homes for the aged in Ontario, but from the hospital sector. We have closed hospital beds in all three provinces. Further, we have converted some acute care hospitals to chronic care hospitals in two of the provinces. So there have been changes in costs and some real savings to the system, not in long-term care, but in the acute hospital sector. It has taken variably between six and twelve years of operation within local areas (sub-provincial areas) to produce those savings. It does not happen overnight. But there are asvings. Part of the lack of long-term care savings occur because our population over 65 is growing very rapidly. The over 65 population is growing at a rate of almost 2 percent per year in our provinces. When you are growing at a rate of 2 percent per year, to be able to save monies, in a program which is highly utilized by that population, is important. Approximately 70 persent of the long-term care in Canada is consumed by those over the age of 70. That, I think speaks volumes in terms of why the savings are least evident in long-term care.

Office Of Continuing Care

The Office of Continuing Care is responsible for the province-wide coordination of Home Care as well as assessment for placement into personal care homes.

This office has responsibility for program direction and management including the establishment and maintenance of standards, program monitoring and evaluation, staff development, and liaison with other components of the health care system.

The program is delivered through the department's regional offices and sub-offices, and through five designated rural health centres. In Winnipeg there is also service delivery through four coordinating hospitals and short term services (under 60 days) are delivered through the Victorian Order of Nurses.

Home Care

The Home Care portion of the program continues to provide an alternative to institutional care by assisting individuals who require support services in order to remain at home. As a part of this program respite care is arranged as a support to families who are providing care.

In 1983 there was further development of several program components. The Continuing Care Program continued to support the concept of independent living for the physically disabled. Homemaking, personal care and home care attendant/orderly services were provided to 37 individuals living in the community in specially modified apartments known as FOKUS I, II and III units. A project for eight tenants similar to FOKUS units was opened late in 1983 by the Luther Home. Preliminary development also occurred in 1983 toward a FOKUS-type project at The Pas and the potential requirement for a FOKUS IV in Winnipeg.

Program staff participated with regional staff in the review of the service delivery of the program at the area and regional levels. A major review of co-ordinated and short-term Home Care delivery service was conducted with the Victorian Order of Nurses of the Winnipeg Hospital.

There has been staff representation on several continuing and special committees concerned with implementing, reviewing and providing recommendations on service delivery related to special housing, services for the younger disabled and the expansion of Adult Day Care.

Program statistics for 1983 indicate that the clients served required a higher level of care. Compared to 1982 figures, the average monthly number of persons receiving services in 1983 demonstrated the following increases: homehelp services 4%; nursing services 9%; auxiliary services 9%; and therapy services 10%.

In 1983, 9,733 persons were admitted to the program compared to 9,687 in 1982. Without the availability of Home Care - 17% of persons admitted to the program this year would have required Personal Care Home Placement; 46% would have been admitted to or remained in hospital and 37% would have been in the community without appropriate care. The percentage of persons who would have required hospital care increased 40% over the previous year.

The number of persons discharged from the program in 1983 increased 8.3% compared to 1982. Of the 9,419 persons in 1983 who were discharged from the program 9% were placed in a personal care home; 14% were admitted to hospital; 39% improved to the extent that their care could be managed personally or by family; and 17% were deceased.

The Home Care Program recruits and provides part-time community employment for professionals and para-professionals. Approximately 2,000 persons are employed on part-time basis to deliver homemaking and personal care services per month. In addition, 219 Registered Nurses, 107 Licensed Practical Nurses and 223 home care attendants provided nursing and personal care services. Therapy services are provided through Community Therapy Services of Manitoba.

In 1983 the program continued to benefit from the work of volunteers who provide services such as meal delivery, friendly visiting and daily telephone reassurance.

Personal Care Home Placement

For some individuals the most appropriate care alternative is placement in a personal care home. The number of people on the waiting list for placement as of December 31, 1983 increased 12% in the rural areas and 20% in the Winnipeg area as compared to the same period in 1982. The increase in the waiting list has been highest at the Extended Care III and IV levels.

Table 1
Maximum Number of Persons Receiving Co-ordinated Home Care Services[1]
By Region, January to December, 1983

REGION	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
Central	681	672	689	699	725	721	727	747	751	748	745	731
Eastman	593	578	582	585	593	597	603	653	605	616	638	627
Interlake	687	689	716	727	731	746	738	721	741	723	744	734
Norman	282	282	288	286	288	295	292	289	291	291	291	286
Parkland	586	572	575	584	606	641	644	638	642	636	610	608
Thompson	82	74	70	75	79	75	79	84	89	90	84	80
Westman	1,301	1,207	1,175	1,153	1,156	1,147	1,137	1,139	1,137	1,138	1,155	1,146
Winnipeg	7,383	7,304	7,416	7,335	7,453	7,433	7,530	7,514	7,659	7,638	7,772	7,721
Total	11,595	11,378	11,511	11,444	11,631	11,655	11,750	11,785	11,915	11,880	12,039	11,933

[1] The maximum number of persons receiving home care during a month is greater than at month end, as admissions exceed discharges.

Table 2
Home Care Program Caseload Movement by Age Group
January 1 to December 31, 1983

CASELOAD	AGE 0-18	AGE 19-64	AGE 65 +	TOTAL
At Beginning of January	268	2,047	8,331	10,646
Admissions	236	2,375	7,122	9,733
Discharges	240	2,277	6,902	9,419
At End of December[1]	265	2,135	8,600	11,000

[1] Year end count does not balance due to age reclassification and the fact that transfers in and out may not be reported in the same month. In 1983, 40 more transfers in than out were reported.

Table 3
Home Care Program: Average Monthly Number of Persons Receiving
Selected Services[1] by Category – January to December, 1980 to 1983

SERVICE[2]	AVERAGE MONTHLY NUMBER OF PERSONS			
	1980	1981	1982	1983
Nursing Service[3]	3,329	3,330	3,587	3,900
Auxiliary Service[4]	1,280	1,733	2,089	2,269
Therapy Services[5]	272	281	309	341
Home Help Service[6]	5,192	5,865	6,518	6,790

[1] In addition, Home Care Services include health supervision, health education, health counselling, social service counselling, as well as volunteer services such as shopping, friendly visiting and daily telephone reassurance.

[2] An individual can receive more than one category of service.

[3] Professional registered nursing services provided in the home.

[4] Services provided by L.P.N.'s, aids and orderlies.

[5] Includes occupational and physiotherapy services.

[6] Includes household duties and/or personal care.

NOTE: These statistics only include paid services and exclude services performed by public health nurses, social workers, and other departmental staff.

Table 4
Number of Persons on the Waiting List for Personal Care Homes
At End of December 1980 to 1983

	1980	1981	1982	1983
Total Rural Area	1,079	893	717	803
Winnipeg	711	519	727	874
TOTAL	1,790	1,412	1,444	1,677

Table 5
Percentage of Persons on Waiting List Receiving Home Care
Pending Placement, December 1980 to 1983

	1980	1981	1982	1983
Total Rural Area	36.3	36.2	36.7	31.0
Winnipeg	27.0	16.4	49.0	44.9
TOTAL	32.6	28.9	42.9	38.2

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The program is delivered through the department's regional offices and sub-offices, and through five designated rural health centres. In Winnipeg there is also service delivery through four coordinating hospitals and short term services (under 60 days) are delivered through the Victorian Order of Nurses.

Home Care

The Home Care portion of the program continues to provide an alternative to institutional care by assisting individuals who require support services in order to remain at home. As a part of this program, respite care is arranged as a support to families who are providing care.

In 1984 there was further development of several program components. The Continuing Care Program continued to support the concept of independent living for the physically disabled. Homemaking, personal care and home care attendant/orderly services were provided to 37 individuals living in the community in specially modified apartments known as FOKUS I, II and III units. A project similar to the FOKUS units, serving eight clients was operated by the Luther Home. Developments continued in 1984 towards a FOKUS-type project at The Pas and a FOKUS IV unit in Winnipeg.

In August 1984, the Manitoba Home Care Orderly Service was introduced to meet the needs of those physically disabled and other Home Care clients who require assistance with personal care. An implementation committee composed of consumers of the service, departmental and program staff was appointed by the Health Minister to guide the development of the service. The number of persons receiving this service has increased from 206 at the program's inception to 356 persons as of December 1984.

During 1984, program staff participated with regional staff in the review of the service delivery of the Continuing Care program at the area and regional levels. In cooperation with the Victorian Order of Nurses, the Office of Continuing Care conducted a major review concerning the role of referral nurses from Home Care offices within Winnipeg hospitals, in facilitating the discharge of patients to the community.

Program staff continue to provide consultation and direction to departmental and community-based services related to Home Care and Personal Care Home Placement. There has been staff representation on several continuing and special committees concerned with program development, review and recommendations related to service delivery concerning special housing services for the young disabled persons, the expansion of Adult Day Care, support services for seniors, hospital and patient discharge planning. Staff have also participated on several inter-departmental review committees dealing with topics such as health

The Office of Continuing Care has supported the ongoing development of professional knowledge and skill through the sponsorship of a two-day staff development workshop for case coordinators and program supervisors on family therapy. Homemakers, who required additional skills in meeting the personal care needs of clients whose needs have increased, were provided with training modules. These modules are at a level which meets the requirements of the Red River Community College for a Home Care Attendant certificate.

Program statistics for 1984 indicate an increase in the number of clients receiving specific services. Compared to 1983 figures, the average monthly number of persons receiving services in 1984 demonstrated the following increases: homehelp services 8%, auxiliary services (LPN, orderlies, Home Care Attendants) 5%; and therapy services 3%. The number receiving Nursing services was relatively the same in 1984 as in 1983.

In 1984, 10,221 persons were admitted to the program compared to 9,733 in 1983. Without the availability of Home Care, 20% of persons admitted to the program this year would have required Personal Care Home Placement, 44% would have been admitted to or remained in hospital and 36% would have been in the community without appropriate care.

The number of persons discharged from the program in 1984 was down marginally. Of the 9,376 persons in 1984 who were discharged from the program 9% were placed in a personal care home; 15% were admitted to hospital; 39% improved to the extent that their care could be managed personally or by family; 15% had service provided by others; and 17% were deceased.

The Home Care Program recruits and provides part-time community employment for professionals and para-professionals. As of December 31, 1984 approximately 2,200 persons were employed on a part-time basis to deliver homemaking and personal care services. In addition, 249 Registered Nurses, 122 Licensed Practical Nurses and 390 Home Care Attendants provided nursing and personal care services. Therapy services are provided through Community Therapy Services of Manitoba.

In 1984, the program continued to benefit from the work of volunteers who provide services such as meal delivery, friendly visiting and daily telephone reassurance, transportation and escort service.

Personal Care Home Placement

For some individuals the most appropriate care alternative is placement in a personal care home. The number on the waiting list for placement as of December 31, 1984 increased 26% in the Winnipeg area and decreased 13% in rural areas as compared to the same period in 1983. The provincial total demonstrated a 7% increase. This year the rate at which personal care home beds became available for new admission was significantly lower than in 1983.

Table 1
Maximum Number of Persons Receiving Co-ordinated Home Care Services
By Region — January to December, 1984

REGION	JAN.	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.
Central	744	762	758	750	740	731	711	723	755	773	797	795
Eastman	651	654	650	660	669	670	681	681	692	703	713	715
Interlake	747	749	746	753	785	792	824	831	850	856	868	868
Norman	290	292	297	297	303	300	307	310	307	313	321	326
Parkland	617	610	634	629	640	643	637	641	639	639	652	650
Thompson	80	79	79	89	89	78	84	85	86	85	90	93
Westman	1,130	1,114	1,132	1,153	1,155	1,150	1,186	1,220	1,192	1,207	1,125	1,106
Winnipeg	7,632	7,750	7,666	7,468	7,625	7,770	7,713	7,776	7,810	7,921	8,096	8,098
Total	11,891	12,010	11,962	11,799	12,006	12,134	12,143	12,267	12,331	12,497	12,662	12,651

CONTINUING CARE

Part 4
Tables 2 & 3

Table 2
Home Care Program Caseload Movement by Age Group
January to December, 1984

	AGE			
	0-18	19-64	65+	TOTAL
At Beginning of Year	258	2.101	8.633	10,992[1]
Admissions	219	2.326	7,676	10,221
Discharges	217	2.104	7,055	9,376
At End of Year[2]	262	2.321	9.276	11,859

[1] Revised

[2] Year end count does not balance due to age reclassification and the fact that transfers in and out may not be reported in the same month.

Table 3
Home Care Program: Average Monthly Number of Persons Receiving Selected Services[1] by Category — January to December, 1981 to 1984

SERVICE[2]	AVERAGE MONTHLY NUMBER OF PERSONS			
	1981	1982	1983	1984
Nursing Service[3]	3.330	3.587	3.900	3.891
Auxiliary Service[4]	1.733	2.089	2.269	2.375
Therapy Service[5]	281	309	341	350
Home Help Service[6]	5.865	6.518	6.790	7.323

[1] In addition, Home Care Services include health supervision, health education, health counselling, social service counselling, as well as volunteer services such as shopping, friendly visiting, and daily telephone reassurance.

[2] An individual can receive more than one category of service.

[3] Professional registered nursing services provided in the home.

[4] Services provided by L.P.N.'s and home care attendants.

[5] Includes occupational and physiotherapy services.

[6] Includes household duties and/or personal care.

NOTE: These statistics only include paid services and exclude services performed by public health nurses, social workers and other departmental staff.

Table 4
Number of Persons on the Waiting List for Personal Care Homes at End of December, 1981 to 1984

	1981	1982	1983	1984
Total Rural Area	893	717	803	701
Winnipeg	519	727	874	1,099
TOTAL	1,412	1,444	1,677	1,800

Table 5
Percentage of Persons on Waiting List Receiving Home Care Pending Placement — December, 1981 to 1984

	1981	1982	1983	1984
Total Rural Area	36.2	36.7	31.0	43.8
Winnipeg	16.4	49.0	44.9	47.2
TOTAL	28.9	42.9	38.2	45.9[1]

[1] Of the total waiting placement, 45.9% were on the Home Care Program, 42.7% were in hospital and the remaining 11.4% in Community were being totally cared for by family and/or friends.

A TEN-POINT MODEL FOR HOME CARE DELIVERY

Carolyn Ewanchyna, Donna Collins and Jeanette Block

THE 11TH INTERNATIONAL CONGRESS OF GERONTOLOGY

Tokyo, Japan
August 22, 1978

Unpublished Paper for Discussion
Purposes, only

A TEN POINT MODEL FOR HOME CARE DELIVERY

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UNPUBLISHED PAPER FOR DISCUSSION PURPOSES, ONLY

Home care programs emerged as an essential component of health care for the elderly and were generally based on hospital or community models. These models co-existed in Manitoba, as elsewhere, but services were uncoordinated, fragmented, restrictive, duplicative and not universally available. In September, 1974, a comprehensive Home Care Program was implemented, incorporating traditional models and new components. It was based on the following ten points: establishment of a central government office for funding, program planning and coordination; delivery at regional and subregional levels through existing community-based Health and Social Development teams; eligibility determined by a multi-disciplinary assessment of need; accessibility through multiple entry; use and coordination of services of private and community agencies and volunteers; use of professionals and non-professionals; systematic data collection; monitoring and review; provision for a continuum of care among home, hospital and personal care homes; and a universal, no charge to consumer system. Three years of experience have validated the applicability of this model for Manitoba and its potential utility in other jurisdictions. It provides flexibility and accessibility to a wide spectrum of care and services and is a viable alternative to institutionalization.

INTRODUCTION

This paper describes the ten components of a model for Home Care as it exists in Manitoba, a province in central Canada.

Manitoba is a jurisdiction more than twice the total area of the British Isles with a population of approximately one million persons. More than half this number reside in one metropolitan area, while most of the remainder live in small cities, towns, villages, and on farms in

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1. Program Specialists, Office of Continuing Care, Manitoba Department of Health and Social Development, 831 Portage Avenue, Winnipeg, Manitoba, Canada, R3G 0N6, with assistance from Enid Thompson, Director, Margaret Barbour, Program Evaluator, Maria Haroon, Program Analyst, Office of Continuing Care, and Betty Havens, Director of Research, Manitoba Department of Health & Social Development.

Southern Manitoba. Some seven percent live in isolated wilderness areas that reach north to Hudson Bay. Ten percent of the total population of the province are age 65 and over.[2]

The Home Care Program in Manitoba is a comprehensive community-based program providing a broad range of services to meet the needs of persons assessed as requiring assistance or support at home. The program provides services to persons whose functioning without Home Care is likely to deteriorate, making it impossible for them to remain at home in the community. Following identification of needs, services are organized in order to avoid deterioration and to maintain or enhance health.

Types of services offered include multidisciplinary assessment of total needs; individual and family counselling; health teaching; surveillance; supervision of medications; rehabilitative therapy; homehelp services, such as meal preparation, light cleaning & laundry; personal care services, including assistance in grooming, bathing, dressing, eating; medical equipment & supplies; and community and volunteer services.

Services provided to each person are designed to fill the gap between what the individual and family can provide, and what is needed in order to remain in the community. Minimum services are delivered in order to foster a maximum degree of independent functioning and to minimize dependence.

The program, which began in September 1974, is designed to provide both short and long term care in the home. Although it serves all age groups, 75% of those enrolled on the program are age 65 and over.

The Manitoba model evolved within the context of the provincial health policy of the early nineteen seventies. This policy aimed at reducing fragmentation through the integration of health care delivery. Previously the emphasis in the delivery of health care, particularly for the elderly, was primarily based on institutionalization. Both hospitals and nursing homes were insured services resulting in premature, expensive placement in care facilities and/or overstay of persons in hospitals.

Various models of home care co-existed in Manitoba for many years. These models were both hospital and community-based and delivered

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2. For additional detail on this and other statistics see Home Care Program Statistics,p 11.

through private and government agencies.

A study of the needs of the elderly in Manitoba (Aging in Manitoba 1971), revealed that the elderly themselves wanted more community support systems. This study indicated that resources in the community were inaccessible to the elderly, that a very low percentage of elderly persons had patterns of needs which would be met most appropriately through placement in an institution (i.e., extended care hospital or nursing home). A high percentage had needs which would be met most appropriately by housing, home care and community service programs, supporting the need for a comprehensive home care program.

A working group established by government in January 1974 found that with the various agencies delivering care, services were uncoordinated, fragmented, restrictive and not universally available. This group examined the characteristics of various community and facility based models of home care. Their report[3] recommended a comprehensive, coordinated home care model which would be community based, would offer multidisciplinary assessment and a broad range of services and which would be integrated with assessment for placement in nursing homes. Such a program would provide an alternative to institutional care, would allow the most economical use of resources, reduce fragmentation, gaps and overlaps, and would deliver the most appropriate service(s) at the lowest cost.

As a result, the decision was taken to establish a program-office charged with the responsibility for coordinating the existing fragmented pieces of home care services into a coordinated, comprehensive, province-wide Home Care program.

I. THE FIRST COMPONENT IN THE MANITOBA HOME CARE MODEL IS THE ESTABLISHMENT OF CENTRAL PROGRAM COORDINATION AND MANAGEMENT.

An Office of Continuing Care, within the Department of Health and Social Development, was established as a central program office, charged with the responsibility of developing this comprehensive province-wide care program. In support of this mandate this Central Office of Continuing Care was given responsibility for program planning and development, for recommending on policy for admission, services, and standards, as well as responsibility for program evaluation and management of all government

3. A Home Care Program for Manitoba. An unpublished report, Manitoba Department of Health and Social Development, Winnipeg, April, 1974

budgetted funding for home care services.

Through the efforts of this Office, the roles and functions of existing agencies providing services were redefined and new service components were added to provide a network of regional coordinating agencies capable of delivering services throughout the province. The Victorian Order of Nurses, previously providing a nursing and home help service within a restricted program in the major metropolitan City of Winnipeg, was designated as the coordinating agency for delivery of services under the new comprehensive program for those in Winnipeg requiring short-term (under 60 days) services. The hospital based programs in the major metropolitan hospitals were designated to coordinate service delivery for those requiring care in the community in combination with highly specialized or intermittent hospital care. Departmental regional offices, already responsible for the delivery of other government and social service programs, were designated as coordinating agencies, for long-term care in Winnipeg and for total care under this new program, in all other regions throughout the province. Integration of assessment for placement into nursing homes with assessment for home care services has been achieved through the locating of program responsibility for the assessment for placement with the Central Office of Continuing Care, through continuing the role of departmental regional offices in assessment for placement and through expanding the role of the hospital-based home care offices in the metropolitan hospitals to include assessment for placement into nursing homes.

With this model, any citizen in Manitoba with care needs not requiring hospital care, will relate to one coordinating agency capable of assessing care needs and capable of either organizing services to provide care at home in the community or capable of arranging placement into a nursing home. All coordinating agencies utilize the same policy guidelines to ensure some consistency and standards in services offered and provided. All coordinating agencies utilize the same case record forms to support consistent, comprehensive assessment and explicit care planning, and to facilitate the collection of service and program information across agencies and regions. A central registry of all persons receiving services prevents any duplication in agencies providing service and assumes continuity of care for those persons who relocate across the province.

This model then, provides centralized coordinated program planning and management through a network of coordinating agencies combined with decentralized local service delivery.

II. THE SECOND COMPONENT IN THE MODEL IS DECENTRALIZED SERVICE DELIVERY THROUGH AN AGENCY AND REGIONAL MANAGEMENT SYSTEM.

Each regional coordinating agency is responsible for participating with the central program office in program planning and development to assure that regional and local needs are accommodated. Each coordinating agency is also responsible for program management and interpretation at the local level and quality service delivery within program guidelines.

A staff person in each of the eight regional areas in the province, designated as the regional Continuing Care Coordinator, has responsibility for this overall program management.

It is the field staff of the coordinating regional office, sub-offices or agency who determine the need for service, arrange for the delivery of services and in most instances, these are the same staff who deliver a variety of health and social services. The use of these regular regional staff for home care delivery ensures that the program operates as an integral part of the health and social service system and facilitates continuity of service for those in need of service under other programs. This also facilitates easier accessibility to service and promotes local community involvement in service delivery.

This staff includes public health nurses, social workers, mental health workers, mental retardation workers, health educators and home economists. This provides the base for multi-discipline assessment of need and care planning and for professional coordination and supervision of delivered services.

Employment of professional and non-professional persons from the local community to provide the delivered services completes the pattern for service delivery at the local level.

III. MULTIPLE ENTRY IS THE THIRD COMPONENT IN THIS MODEL.

Persons can gain entry to the Manitoba program in a variety of ways and can receive service based on any level of need, a single need or combination of needs. They may refer themselves or be referred by family, friends, or any part of the health care system such as physicians, clinics, or hospitals. Individuals have access to a broad range of services and they receive any or only the selected service(s) they require based on assessment. It is not necessary that a person receive any one type of service before another is provided. For example, a person does not have to require nursing service in order to receive home help or any other service.

This model, then, places no restrictions on how a person who may require service to remain at home may come to the attention of the program and it stresses that any need is as important as any other need when it is a matter of supporting the individual's continued functioning at home in the community.

IV. THE FOURTH COMPONENT IS ELIGIBILITY BASED ON NEED.

In this model, eligibility to receive service and the nature and extent of service to be provided is determined on the basis of a comprehensive assessment of the individual in his home and community setting. When a person is referred or applies for service, a professional staff person of the coordinating agency is designated as the case coordinator responsible for coordinating assessment of the individual's need for service. This coordinator is usually a public health nurse or social worker. There will be contact with the attending physician. There will be assessment of the individual's health and social functioning. There is thus a coordinated assessment of needs for care by one or more professionals within a multidisciplinary team. This assessment identifies strengths and lifestyles, the clinical status, present and potential functional abilities of the individual and capability of the family and community to meet all or part of the assessed needs.

On the basis of this assessment, a care plan is developed with the individual and family which identifies what services will be performed by family members and those services which will be delivered by the program. This care plan also outlines goals to be achieved through the provision of service and when the need for service should be reassessed. Services are increased, decreased, terminated or new services are introduced through assessment and reassessment.

V. A FIFTH COMPONENT IS THE USE OF BOTH PROFESSIONALS AND NON-PROFESSIONALS WITHIN THE PROGRAM.

While in this model, the coordination of assessment and care planning and the coordination and supervision of services delivered is provided by professional staff of the coordinating agency, the program uses both professionals and non-professionals in the delivery of services in the home. The manpower for this service delivery is recruited from the community by the regional/local coordinating agency. These include registered nurses, licensed practical nurses, aides, orderlies, therapists, home attendants, home helpers, personal care attendants, and volunteers - persons with skills as varied as the services to be performed.

In the organization of services to be delivered, emphasis is placed upon using the person possessing the minimum skill required to provide that service.

In this model, where such manpower is recruited locally, local communities are provided with part-time employment opportunities, it becomes possible to provide services to the population which is located in small communities scattered throughout a large geographical area and it has been found relatively easy to hire and to retain this needed personnel.

VI. THE SIXTH COMPONENT IS USE AND COORDINATION OF SERVICES FROM THE PRIVATE SECTOR, COMMUNITY AGENCIES AND VOLUNTEERS.

Any service in the community can be made available and coordinated into the care plan of the person in receipt of home care.

In addition to the manpower pool recruited by local coordinating agencies, the Home Care program utilizes, as required, through purchase or referral, the services provided by community agencies. Examples include the purchase of occupational and physical therapy assessment and treatment services from The Arthritis Society, a private non-profit agency providing a field service throughout Manitoba. The Victorian Order of Nurses, also a private non-profit agency, functioning as a coordinating agency in Winnipeg for short-term care, is the agency from whom nursing service is purchased for the delivery of direct service for long term care coordinated by the government regional coordinating agency. Adult Day Care can be purchased or obtained, on referral, from several nursing homes throughout the province: day-hospital care and short-term hospital relief care can be obtained, on referral, from several hospitals.

Volunteer services are utilized by the program either through the direct recruitment of individual volunteers by a coordinating agency or through utilizing the volunteer services offered by community agencies. Volunteer services utilized include meals delivery, friendly visiting, daily telephone reassurance, transportation, escort, shopping and handyman service.

In this model throughout the emphasis has been for the development of a comprehensive Home Care program through the coordination of all existing agencies and services and through the development of new service components through the support of community service development where appropriate and possible.

VII. THE SEVENTH COMPONENT IS THE PROVISION OF A CONTINUUM OF CARE AMONG HOME, HOSPITAL AND NURSING HOMES.

To assure that community-based home care services could be appropriately and immediately responsive to the home care needs of those being discharged from hospital and that there could be continuity of care for those moving in and out of hospital care or from home care or hospital care to nursing home care, this model called for special linkages to be established between hospitals and the community-based home care services. This was in addition to the integration of assessment for Home Care with assessment for placement into nursing homes which would provide linkages for continuity from home care to nursing home care. It was also in addition to the integration of the delivery of home care service with other community health and social services to provide a continuity in the provision of services with the community health and social service system.

The linkages called for in this model were put into place through continuing the former case-finding and discharge roles of the metropolitan hospital-based home care offices and through the part-time assignment of local home care coordinating staff to the many small hospitals throughout the province. These coordinators provide liaison between community workers and hospital staff in the development of a care plan for those entering or leaving hospital and local community staff visit the person at home to provide support services related to the care plan.

At the program delivery level in Manitoba, these linkages do serve to support the provision of home care or nursing home care based upon an integrated assessment, the appropriate provision of home care services to facilitate discharge from hospital, the utilization of both home care and hospital care to provide a continuum of care, continuity in care for those being discharged from any hospital to any part of the province as well as the utilization of home care for those awaiting placement into a nursing home.

The establishment, in this model, of a central program office has provided one central focus for conjoint planning of Home Care with other parts of the health care system. While improvements and developments still lie ahead, many changes have made the total system more accommodating to the needs of citizens and innovative developments for new services have occurred. Examples of this include the development of a priority system to assure that those most in need of nursing home placement would be placed, conjoint planning for improved accessibility to community services for the elderly residing in housing projects and new developments such as Home Dialysis and home-based antibiotic therapy treatment.

VIII. MONITORING AND REVIEW IS THE EIGHTH COMPONENT.

This model of Home Care provides for the reassessment of services delivered to the individual and for the monitoring and review of program delivery and effectiveness.

Program guidelines require that all Home Care cases be reassessed as required to assure appropriate service delivery and that such case reviews occur at least every three months. These case reviews are held within local coordinating offices, are carried out by case coordinators in conjunction with other staff involved in the case. There is a review of the care plan to determine whether objectives are being achieved in order to revise the care plan if indicated, and to ensure appropriate input of service and use of resources.

Program Reviews are established as the responsibility of regional/agency coordinators and are held at least every six months.

Program specialist staff from the central program office, responsible for monitoring standards and the development of adequate standards, participate in these case and program reviews. This ensures that program guidelines are being followed and that objectives are being met. This also reinforces and assists in the development of the multi-disciplinary focus of assessment and care planning. The review process provides an ongoing opportunity for program interpretation and for identification of local concerns and issues, for further program development regionally and provincially. The overall status of program delivery and program planning in each regional coordinating agency is reviewed by central office directorate staff in conjunction with coordinating agency management staff at least annually for budgetary and program planning and development purposes.

IX. THE NINTH POINT IS SYSTEMATIC DATA COLLECTION.

The important features of the data collection system in this Manitoba model of Home Care are that the same data are collected from across all coordinating agencies and that the total data system has been organized to provide for the use of program and service information with program expenditure information for geographical regional and sub-regional areas of Manitoba. This data system thus supports program monitoring and planning at the regional and sub-regional levels as well as at the central level. It also makes possible, the use of program data with other program and population data available to these same geographical areas.

The data system in place in Manitoba is largely a manual system. While this does limit the amount of information available, the design of this data system does maximize the use which can be made of the data produced by regional and central program staff in monitoring service delivery costs and for program planning and development purposes.

X. THE TENTH COMPONENT IS A UNIVERSAL NO CHARGE TO CONSUMER SYSTEM.

The Home Care program in Manitoba is government funded from general tax revenue and available without charge to those individuals for whom care at home is assessed as being the most appropriate care. In Manitoba, hospital care and care in a nursing home[4] are provided without charge as insured services under a general tax supported health insurance program. In this Manitoba model Home Care is therefore considered as valid a service as are institutional services. This prevents any monetary incentive to overuse of institutional care and thus reduces the possibility of inappropriate utilization of care facilities. It clearly supports Home Care as a vital component of the health care system.

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[4] In Manitoba care in a Nursing Home is provided with no charge to the resident. There is a per diem charge for room and board.

HOME CARE PROGRAM STATISTICS

The Home Care Program data system is a manual system which does not limit the amount of available information but does limit the amount and extent of the statistical analyses.

The following program statistics have been selected for inclusion in this report as they provide information on the population served by the program, source of referrals, admission, discharges, persons receiving selected home care services, alternatives to home care and cost comparisons.

Population Served:

A very small percentage of the population of Manitoba received Home Care Services in 1978. The 15,395 persons enrolled in the program constitute only 1.4% of the total population of the province.

A further analysis of the 1978 program statistics shows that persons age 65 and over made up the largest proportion of the caseload. The age groupings of the persons served by the program is shown in Table I.

TABLE I NUMBER OF PERSONS ADMITTED,
DISCHARGED AND TOTAL NUMBER SERVED BY THE HOME CARE PROGRAM IN 1978
BY AGE GROUP

Age Group	Admissions	Discharges	Total Persons Served
0 - 19 years	293	330	620
19 - 64 years	1899	1948	3525
65+	5456	5602	11250
Total	7648	7880	15395

Of those receiving Home Care 73% were elderly persons, 23% were adults and 4% were children. The 11,250 persons age 65+ receiving home care services constitutes 9.8% of the elderly population in Manitoba.

Source of Referrals:

The referral for persons admitted to the Home Care Program came from a variety of sources as shown in Table II.

TABLE II NUMBER & PERCENT OF ADMISSIONS TO THE HOME CARE PROGRAM IN 1978
BY SOURCE OF REFERRAL

Source	Number of Persons	Percent
Hospitals	3696	48
Private Physicians	1475	19
Family or Friends	1235	16
Self	582	8
Other Agency Staff	354	5
Departmental Staff	306	4
Total	7648	100

Almost half of the referrals were made by hospitals.

Discharges from the Home Care Program:

The majority of the persons discharged from the program no longer required care or their care could be provided by the family as in table III.

TABLE III NUMBER & PERCENT OF DISCHARGES FROM THE HOME CARE PROGRAM IN 1978
BY REASON FOR DISCHARGE

Reason	Number	Percent
Improved & No Longer Need Care	3041	38.5
Improved so Care Can be Managed by Family	1324	16.8
Deceased	1112	14.1
Admitted to Hospital	1072	13.6
Placement in Personal Care Home	699	8.9
Miscellaneous Other Reasons	632	8.
Total	7880	99.9

Since the inception of the program the number of terminally ill persons who are cared for at home by family members supported by the Home Care Program has been increasing.

Home Care Services:

The Home Care Program provides services to an average of 8,299 persons in a month. The average number of persons receiving selected services in a month is shown in Table IV.

TABLE IV THE AVERAGE MONTHLY NUMBER OF PERSONS
AND PERCENT OF AVERAGE MONTHLY CASELOAD RECEIVING SELECTED HOME CARE SERVICES (1)
BY CATEGORY IN 1978

Service (2)	Average Monthly Number of Persons	Percent of Average Monthly Caseload
Home Help Services (3)	3835	46%
Nursing Services (4)	2871	35%
Auxiliary Services (5)	845	10%
Therapy Services (6)	328	4%

1) In addition, Home Care Services include health supervision, health education, health counselling, and social services counselling as well as volunteer services such as shopping, friendly visiting and daily telephone reassurance.

2) An individual can receive more than one category of service.

3) Includes household duties and/or personal care.

4) Professional registered nursing services provided in the home.

5) Services provided by L.P.N.'s, aides and orderlies.

6) Includes occupational and physiotherapy services.

Alternatives to Home Care:

When a person is admitted to the Home Care Program an assessment is made of the type of care that an individual would require were home care not available. The alternatives to Home Care for the 7,648 persons admitted to the program in 1978 is shown in Table V.

TABLE V THE NUMBER & PERCENT OF PERSONS ADMITTED TO HOME CARE IN 1978
BY ALTERNATIVES TO HOME CARE

Alternative (1)	Number of Persons	Percent
Remain at Home without home care services	3119	41
Admission to Hospital	2493	33
Placement Personal Care Level II	1173	15
Placement Personal Care Hostel	677	9
Placement Personal Care Level III - IV	186	2
Total	7648	100

(1) Alternatives are listed in descending order of frequency and percentage rather than the assessed level of care required.

Cost Comparison:

The average monthly cost of providing home care services in 1978 was $84.00 for each person served. This amount includes direct service costs, salary costs and some administrative and program operational costs. The cost of providing the alternative level of care is based on information provided by the Manitoba Health Services Commission. The per diem rates for the three levels of care provided in personal care homes varies from region to region throughout the province. Each year the Commission provides the Home Care Program with a median per diem rate for each level of care. In 1978 the per diem rates, not including the $7.00 per day paid by the residents, for each level of care were as follows: Hostel $7.40 ($222.00 per month), Personal Care Level II $15.70 ($471.00 per month), Personal Care level III/IV $25.78 ($773.40 per month).

The hospital per diem rates established for 1978 for persons awaiting placement were $53.68 ($1610.40 per month) for rural hospitals and $72.51 ($2175.30 per month) for Winnipeg hospitals.

The cost comparison between providing the alternative level of care and home care services in an average month is shown in Table VI.

TABLE VI A COMPARISON OF THE COST OF PROVIDING THE ALTERNATIVE LEVEL OF CARE AND HOME CARE FOR THE AVERAGE NUMBER OF PERSONS ADMITTED TO THE HOME CARE PROGRAM DURING ONE MONTH* IN 1978

	n=56 Hostel	n=98 Level II	n=16 Level III/IV	n=208 Hospital	n=260 Remain At Home	Total
	$	$	$	$	$	$
Cost of Alternative Level of Care	12342	46758	12374	416308	000000	487782
Cost of Home Care Services	4704	8232	1344	17472	21840	53592
Difference	$7638	$38526	$11030	$398836	$(21840)	$434190

* A month is assumed to have 30 days.

The difference in cost between providing care at home and an alternative level of care in institutions including hospital care further supports the viability of providing services in the home to persons at risk of premature institutionalization or of overstay in hospital.

CONCLUSION

The Home Care program in Manitoba has progressed towards meeting the goals established at its inception and the following outcomes have occurred: continuity of care has been strengthened; previously co-existing home care services have been integrated and coordinated into one comprehensive program; duplication of home care services has been overcome; home care has been integrated with other components of the health care system; persons are being appropriately maintained in their own homes without being referred to facilities; the previously rapidly increasing waiting list for nursing home placement is becoming stabilized; progress is being made in the acceptance of care at home as a desirable service option; and care at home is proven as a lower-cost form of care.

These outcomes have demonstrated that this model for community-based Home Care in Manitoba is a viable program for its citizens. Its potential applicability in other jurisdictions is dependent on the degree to which these ten components can be transferred into other existing health care systems and the extent to which community care is valued and needed as an organized form of care.

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THE MANITOBA/CANADA HOME CARE STUDY

AN OVERVIEW OF THE FINDINGS

Policy, Planning and Information Branch
Department of National
Health and Welfare

Également disponible en français sous le titre
"Étude conjointe des gouvernements manitobain
et canadien sur les soins à domicile"

April 1982

PREFACE

This publication is an overview of the findings of the Manitoba/Canada Home Care Study, a joint study launched by the Department of National Health and Welfare and the government of the Province of Manitoba in 1977 to compare the cost of home care to the cost of alternative institutional care.

The views expressed in this document are the responsibility of the authors and do not have formal status, in terms of official acceptance within the Departments involved, nor do they necessarily reflect the policies of either government.

It is hoped that this study will be of benefit to persons working in this area and contribute to the exchange of information in the health and social policy fields.

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PART I

A. INTRODUCTION

In 1977, the Department of National Health and Welfare and the government of the Province of Manitoba agreed to use the Manitoba Home Care program in a study to compare the cost of home care to the cost of alternative institutional care. The Manitoba program presented admirable conditions for such a study for a number of reasons:

1. It offered a comprehensive range of services, was province-wide, and served all age groups;
2. It was a relatively mature program, having been in operation since September 1974; and
3. The information collected as part of its regular operating and review procedures provided excellent data for a study of clients, services and costs.

Agreement was reached between the Policy Research and Long Range Planning Branch[1] of the Department of National Health and Welfare and the Office of Continuing Care of the Manitoba Department of Health and Social Development[2] to conduct a joint study. Data were collected on 1,167 people admitted to the Manitoba Home Care program in February and March of 1978.

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[1] Now the Policy, Planning and Information Branch, NHW.

[2] Now the Departments of Health and Community Services.

B. THE SCOPE AND DESIGN OF THE STUDY

The purpose of the Manitoba/Canada Home Care Study was to examine the client characteristics, services received, and costs of services provided to clients on intake in a comprehensive, universal home care program.[3] Each of these factors was examined by grouping clients by their designated alternative level of placement (DALP)[4] as determined by home care workers during the assessment at admission of clients to the program. As well, the costs of home care were compared to the cost of institutional care, and an attempt was made to determine which factors had the greatest influence on costs at each alternative level of placement, and on differences between these levels. In brief, this study tests the assumption that home care is a less expensive alternative to institutional care, and specifies by how much, for each type of client, and for each type and amount of service required.

C. THE SETTING OF THE MANITOBA/CANADA HOME CARE STUDY: AN OVERVIEW OF THE MANITOBA HOME CARE PROGRAM

The Manitoba Home Care program, created in its present form in September 1974, is the oldest province-wide, centrally co-ordinated, universal home care program in Canada. It has served as a model for home care program development in a number of other provinces.

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[3] It must be noted that all factors considered in this study apply only to home care clients on admission, and not to the total case load of a home care program. Since changes in both the situation and services may occur continuously while an individual is receiving home care, there are, inevitably, differences between the clients and services in the study (i.e., as described and assessed on intake) and the population of the home care program as a whole.

[4] The designated alternative level of placement is the level of institutional care in which the client would likely be placed, were home care services not available. It ranges from personal care home placement, to admission to acute hospital care. In some cases, clients would not qualify for institutional care and would continue to stay at home, without care.

The program is centrally administered and co-ordinated by the Office of Continuing Care, established within the Departments of Health and Community Services, but decentralized in delivery. Co-ordinating the delivery of home care services is the responsibility of the departments' regional or local staff, or an external agency's staff. Such personnel determine the amount and nature of the services to be provided. They may arrange to provide the services themselves and/or to purchase them in the community.

The Office of Continuing Care has responsibility for the co-ordination, standards and policy recommendations for the Continuing Care Program, of which home care is one part and personal care home placement is the other. In Manitoba, it is possible to assess a person for care and then to determine if care needs can be met most appropriately through home care or through placement in a personal care home. An integrated assessment procedure whereby the same people determine the level of placement required for entrants to personal care homes, the designated alternative level of placement for home care clients were home care not available, and the amounts and types of services to be provided through home care, ensures a consistent standard of placement decision judgements throughout the range of the Continuing Care Program. This integrated process, which allows access to the personal care homes or to home care only on the basis of assessed need and appropriateness of care, produces cost efficiencies in the system.

Care in personal care homes, and, of course, in hospitals, is an insured service in Manitoba. To effect a comparable financial arrangement for home care services, they are delivered without charge. Therefore, leaving aside any differences in the per diem charge made for food, housing, laundry, and the like in an institution as opposed to the costs of these items for those living at home, there is neither financial advantage nor barrier for those who enter an institution or remain at home.

The Home Care Guidelines, prepared in April 1975, stated that the basic philosophy of the program was "to assist the individual's progress towards maintaining a state of high level wellness in the familiar environment of his own home".[5] From this general statement of intent, the Office of Continuing Care has developed five objectives for the program:

a) "To develop and provide services in the home as a viable form of care;

b) "To develop and provide services as an alternative to institutional care for those for whom care at home is most appropriate;

c) "To relieve excess strain on family members and, in so doing, prevent the breakdown of a desirable living arrangement and/or the health of the person/persons providing care;

d) "To prevent the premature, expensive placement or over-stay of persons in care facilities (including hospitals) and thus prevent the over-building and/or over-utilization of institutional facilities; and

e) "To continuously evaluate the impact of the program on the target population and other health care delivery systems."

A person may be referred to the program from any source, including him/herself, doctor, hospital, family, friend, or departmental or external agency staff.

A comprehensive assessment of the person in his or her situation is undertaken. In the assessment living arrangements, medical diagnosis and treatment, health functioning (including communication ability, mental health, and personal care), and social functioning (ability to maintain social contacts and to manage household and personal affairs), are examined. After the need for care has been determined, decisions regarding the individual's need for service are based on: (i) what the individual can do for himself or herself; and (ii) what services can realistically be performed by family members or others. Services received from the program may be in the form of direct services to the individual and/or relief to family members or other persons providing care.

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5. Guidelines, Continuing Care, Province of Manitoba, Office of Continuing Care, Manitoba Department of Health and Social Development, April, 1975, p. 1.

Once a person is admitted to the program, a care plan is developed. This plan identifies the goals to be achieved and types of services required, and specifies a date by which any (or all) components of services should be reviewed. Services provided are designed to fill the gap between what the person needs and what the individual, the family, and others can realistically perform. The range of services available includes:

- household maintenance
- personal care and hygiene
- health maintenance
- treatment of disease and disabling conditions
- information and referral, counselling
- personal and family social service
- facility services (e.g. day care, clinics)
- volunteer services (e.g. friendly visiting, meals on wheels, handyman, transportation, etc.)
- supplies and equipment

Only minimum services are provided to foster the maximum degree of independent functioning.

A social worker or a nurse usually assumes responsibility for a client as "case co-ordinator" depending upon which type of supervision is most appropriate. The case co-ordinator is responsible for making contact with the client, updating the assessment, arranging for services, maintaining a progress record, and ensuring that periodic reviews are conducted to determine the need for continuation of care, or any changes required in care.

The regional or area home care co-ordinator maintains an on-going review of the cases. A formal case load review, which includes the regional director, the medical health officer, the home care co-ordinator and other staff involved, is carried out as needed, to achieve an annual review of all case loads. Regional and provincial program reviews are also conducted periodically to evaluate and maintain program efficiency and effectiveness.

D. METHODOLOGICAL PROCEDURES IN THE STUDY

The sample of 1,167 clients is composed of all those persons 19 years of age or older who were admitted or re-admitted to the Manitoba Home Care program during a two-month period (February and March 1978).

All data for the study were collected from available information in the Manitoba Home Care program, with no direct client contact by persons involved in the study. Client data were obtained from various records used in the program as part of the operational information system. Cost data were calculated on the basis of information derived from time studies, budgets, and the Manitoba Health Services Commission.

The client record forms used with all admissions to the home care program provided data specific to age, sex, marital status, living arrangements, source of referral, diagnosis, prognosis, and the type and amount of services to be provided in the first month (up to 30 days) on home care.

In the development of the home care cost data, a detailed analysis was made of all costs incurred by the governmental and non-governmental co-ordinating agencies and also of the costs incurred by government and other organizations providing support to these agencies. Home care costs were calculated both as direct and indirect costs for a given unit of service. Classed as direct costs were the wages and travel expenses of persons delivering the services. Indirect costs included a portion of the administrative, support and supervisory costs incurred by the co-ordinating agency, the central Office of Continuing Care, and any other government agencies providing support service (payroll, accounting, personnel, etc.) to the program.

Information was obtained on all those admitted to home care as to the alternative level of institutional placement which would have been designated for the person had home care not been available. As the designation of the care alternative is normally an on-going activity associated with admission to the Manitoba Home Care program, the staff person who indicated the DALP used in the study was the co-ordinator for each client. In Manitoba, the designated alternative level of placement may be:

1. Remaining at home (without home care);
2. Level I personal care home (hostel) which provides full residential care plus health care and/or supervision at a minimum average of 30 minutes per day (PCH-I);
3. Level II personal care home (personal care) which provides full residential care plus health care and/or supervision at a minimum average of two hours per day (PCH-II);
4. Level III/IV personal care home (extended care) which provides full residential care plus health care and/or supervision at a minimum average of three and one-half hours per day (PCH-III, IV);
5. Non-acute hospital which includes extended care, chronic care or rehabilitation care in a hospital unit or hospital designed for that purpose; and
6. Acute hospital which includes care in an acute care section of a hospital.

The costs used in the study were the actual costs that the government would have assumed for the designated alternative level of institutional care had home care not been available. These costs were identified with the assistance of staff of the Manitoba Health Services Commission, the government agency responsible for administering the insured Personal Care Home/Hospital Program. Median costs were determined for each level of care for each region in the province. These were applied as alternative care costs for each person in the respective region admitted to home care for the length of time this care was determined to be needed during the study period, that is, up to 30 days.

PART II

A PROFILE OF CLIENTS ADMITTED TO THE MANITOBA HOME CARE PROGRAM FEBRUARY AND MARCH, 1978

A. ADMISSIONS TO HOME CARE RELATIVE TO THE PROVINCIAL POPULATION

Persons admitted to a home care program form only a small proportion of any population. In Manitoba, with a population of approximately 735,000 persons 19 years of age and over, less than two-tenths of one per cent (0.16 per cent or 1,167 persons) were admitted to home care during two months of 1978.

One means of determining which factors are associated with admission to home care, and of comparing their relative strengths of association, is through a measure which shall be called here the "relative propensity to be admitted to home care".

"Relative propensity" is a crude measure of the probability that an individual with certain characteristics will be admitted to a home care program. It is calculated by dividing the number of people admitted to the program having selected demographic characteristics by the number of persons with these same characteristics in the total population. The result is then multiplied by 1,000 to obtain the number (or relative propensity rate) per 1,000 of such persons. For example, 126 females admitted to the Manitoba Home Care program in February and March 1978 were between the ages of 80 and 84; at the same time there were 8,101 females in the Manitoba population aged 80-84. Propensity to be admitted to home care for females 80-84 is therefore calculated as follows:

$$\frac{\text{No. of persons of sex}_a\text{ age}_b\text{ admitted to program}}{\text{No. of persons in population of sex}_a\text{ age}_b} \times 1000$$

or $\frac{126}{8101} \times 1000 = 15.55$ or almost 16 females per 1000 population in the age 80-84 group.

This measure is "crude" because admission occurred over a two-month period, while population figures were determined at one point in time (i.e. June 1, 1978) by the Manitoba Health Services Commission.[6] For convenience and clarity, the "propensity", defined above as a measure of the probability of being admitted to home care in Manitoba over a two-month period, was converted to the propensity for a period of one year. It should be noted that comparisons between the annual figures are more significant than the absolute values of the figures themselves, and that this measure is most useful for predicting relative rates of admission to home care between groups with different characteristics.

As an overall trend, relative propensity to be admitted to home care increases with age for both men and women, with the propensity being consistently higher for females. This can be seen in Table 1, where propensity for males ranges from 1.2 per 1,000 men 19-44 years of age, to 93.3 per 1,000 for males aged 85-89; propensity for females ranges from 2.5 per 1,000 for the 19-44 age group to 144 per 1,000 for those over 90 years of age.

Variations in propensity to be admitted to home care by age and sex may be explained largely by three factors:

1. Differences in marital status;
2. Differences in living arrangements; and
3. Differences in longevity by sex.

Each of these factors interacts with the others to enhance or cancel out differences.

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[6] The MHSC is acknowledged as having the most accurate count of persons in the province. A count is taken twice yearly (December and June) so is closer in time to the study than the 1976 inter-census of Canada.

TABLE 1*

Relative Propensity Per 1,000 Population to be Admitted to Home Care Over a Period of One Year by Age Group, Sex, and Marital Status

Age	Single		Married		Widowed		Total	
Group	Male	Female	Male	Female	Male	Female	Male	Female
19-44	2.5	1.2	0.6	2.5	...	...	1.2	2.5
45-64	5.0	7.4	4.3	6.2	17.9	16.7	4.8	8.0
65-69	17.3	32.2	9.3	21.0	37.7	43.3	12.4	29.4
70-74	48.9	40.2	24.8	34.0	59.4	49.5	31.9	42.1
75-79	71.8	58.8	50.1	78.0	71.1	58.2	58.2	64.3
80-84	...	81.7	53.8	110.7	67.4	102.1	55.4	105.1
85-89	...	...	119.4	180.6	65.0	111.4	93.3	113.0
90+	...	...	...	...	81.0	156.5	62.7	144.0
Total No. in study	55	55	242	301	77	384	393	774

The 1976 inter-censal population figures are used because the MHSC data are not available by marital status or living arrangements.
... Number in study too small (5) to make estimate

When marital status is combined with age and sex, two factors appear to explain the differences in propensity to be admitted to home care between males and females: among the younger age groups, an apparent reliance on the traditional female roles of homemaker and child care; and among the older people, the longer life expectancy of women.

While 2.5 women per 1,000 aged 19-44 would be admitted to home care, only 1.2 men in every 1,000 of this age group would likely be admitted. If, however, only married persons within this age group are considered, the propensity for admission remains the same for females (2.5/1,000), but drops by one-half to 0.6 per 1,000 for married males.

The larger proportion of young married women admitted to the home care program, compared to married men in the same age group, suggests that family status and/or the "female role expectations" play a part in home care admission. It is the policy of the Manitoba Home Care program to deliver care based on the circumstances of the person. Thus, if a young mother is ill and the father is out of the home, her role must be fulfilled through home care services, such as homemakers. If a young father is ill, the mother can care for him and the household, unless the mother goes out to work in which case home care services would be needed. Table 2 shows the propensity to be admitted to home care by age group, sex, and living arrangements.

TABLE 2*

Relative Propensity Per 1,000 Population to be Admitted to Home Care Over a Period of One Year by Age Group, Sex, and Living Arrangements

	Live Alone		Live with Spouse Only		Live with Others	
Age Group	Male	Female	Male	Female	Male	Female
19-44	...	...	1.3	4.6	1.5	3.0
45-64	6.3	15.9	7.4	15.6	3.9	4.1
65+	79.6	86.0	34.2	31.7	36.4	73.7

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*The 1976 inter-censal.

"Others" may include a spouse and/or children, siblings, parents or friends of the client living within the same household; 86.6% of the persons in this category in the study lived with family members.

... No. in study too small (≤5) to make estimate.

The propensity to be admitted to home care for persons under 65 years of age is lowest for those who live with others. Among the middle aged, there is little difference in propensity for those living with a spouse or living alone. Thus, for young and especially for middle-aged persons, the presence of other family members in the household appears to reduce the probability of admission to home care. For the older age group (65+) the presence of a spouse is associated with a lower propensity for admission for females. This is probably due to a combination of marital status and life expectancy. Because of the shorter life expectancy of men, women who live with their spouse are more likely to be at the younger end of this age range, with the consequent lower propensity for admission to home care. As well, their spouses would probably have reached the usual retirement age and be at home during the day. In some cases, this would eliminate the need for home care.

The propensity to be admitted to home care is considerably higher for those persons in the older age group who live alone, compared to those who live with their spouse or, in the case of males, with other relatives. For example, 79.6 males and 86 females per 1,000 who are aged 65 years and older and live alone would be admitted to home care over a one-year period, compared to 34.2 males and 31.7 females who live with their spouse. While there is little difference in the propensity to be admitted between males and females who live alone and with spouse only, there are large differences between males and females aged 65 and over who live with others. Since "others" may include a spouse as well as children, other relatives, or friends, one might speculate that many men in this group live with their wives, as well as other family members or friends. Women are more likely to outlive their spouses and thus are less likely to have a husband included in the "others" in the household. An examination of the composition of the "others" group for persons 65 and over in the study supports this. Of those males living with "others" three-quarters live with family members, and for almost half (47.6 per cent), this would include their wives. While 90 per cent of females in the study who "live with others" are living with family members, only 14 per cent of these are living with their husbands. Thus, the similarities in propensity for admission for males who live only with their spouse and for males who live with others are probably largely due to the presence of a spouse among the "others". Conversely, the absence of a spouse for many females who live with others probably accounts for their higher propensity to be admitted to home care.

B. PERSONAL CHARACTERISTICS OF CLIENTS ADMITTED TO THE MANITOBA HOME CARE PROGRAM (FEBRUARY AND MARCH 1978)

More than seven in 10 (71.5 per cent) of the adult clients admitted to the Manitoba Home Care program were aged 65 and over, and almost three in 10 (29.8 per cent) were aged 80 and more. The youngest client in the study was 19,[7] and the oldest was 101 years of age. Females outnumbered males by a ratio of 2:1 overall. Within the 45-64 and 70-84 age groups, there were slightly lower ratios of females to males (1.5:1 and 1.8:1) admitted, but the group aged 90 and over showed a considerably larger concentration of women (3.5 females per male for those 90-94 years of age and 6:1 for those 95 and older). Thus while almost equal proportions of the males and females admitted to home care were 65 years of age and over (71.1 per cent and 71.8 per cent respectively), there were larger proportions of females at both ends of the age range. Almost one-third of the females were 80 years of age or older compared to one-quarter of the males, and 8.9 per cent of the women were under 40, compared to 7.6 per cent of the men.

Preliminary analysis of the data by five-year age groups indicated that there was little difference in propensity to be admitted to home care or in client characteristics prior to age 45; propensities increased above that age. For simplicity four broad age classifications were used: the "young" (19 to 44), the "middle aged" (45 to 64), and two classifications for older persons -- the "young elderly" and the "old elderly". In categorizing clients into the latter two groups, the age/sex categories suggested in a sub-study[8] of unmet needs of elderly persons from the Aging in Manitoba study conducted in 1971, were used. This sub-study classified females between the ages of 65 and 84, and males between the ages of 65 and 79 as "young elderly". Correspondingly, the "old elderly" are females aged 85 or over and males aged 80 or over. Table 3 shows the resulting age-sex distribution in the Home Care Study.

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[7] This is by definition, since people 18 years of age and under were excluded from the study.

[8] "Differentiation of Unmet Needs Using Analysis by Age/Sex Cohorts of an Elderly Population: Aging in Manitoba", Betty Havens and Enid Thompson; paper presented to the 39th Annual Meeting, Midwest Sociological Society, Chicago, Illinois, April 11, 1975 (p. 13).

TABLE 3

Number and Per Cent of Clients Admitted to Manitoba Home Care
by Age Group, and Sex

Age Group	Male		Female		Total	
(Classification)	No.	%	No.	%	No.	%
Young (19-44)	34	8.7	80	10.3	114	9.8
Middle-Aged (45-64)	79	20.1	139	18.0	218	18.7
"Young Elderly" (F 65-84) (M 65-79)	180	45.8	433	55.9	613	52.5
"Old Elderly" (F 85+) (M 80+)	100	25.4	122	15.8	222	19.0
Total	393	100.0	774	100.0	1,167	100.0

Turning to marital status, almost half of the clients are married (46.5 per cent) and four in 10 are widowed. While more females are widowed than married, just over half of all married clients are females (55.4 per cent). Five out of six of the widowed clients are females. The married women tend to be younger with almost half under 65 and almost three-quarters under 75. As would be expected, widowed females are concentrated at the older end of the age range. Almost four in 10 are in their eighties and more than one in 10 are over 90, with only 8.2 per cent under 65 and just over one-third under 75.

Although equal numbers of male and female clients are single, single males represent 14 per cent of the male admissions to home care while single females account for half of that proportion of female admissions (7.1 per cent). Four in 10 single males are under 65 compared to three in 10 single females; fewer than one-tenth of the single men are 80 or older, compared to one-fifth of the single females.

These differences in marital status are reflected in living arrangements. One in 10 young males live alone compared to less than five per cent of the young females. While proportions of males and females living with other family members are roughly similar (59.4 per cent and 67.9 per cent respectively), there are large differences by sex when "other family members" are identified. Six out of 10 females in this age group are living with their children and five out of 10 with their spouse as well; only 35 per cent of males live with their children and 32 per cent with their spouse as well. Almost one-quarter of the males live with their parents or other relatives compared to seven per cent of females.

The largest single group (by age, sex, marital status, and living arrangements) is composed of widowed females, 65-84 years of age (the "young elderly"), who live alone. This group accounts for almost one-sixth (15.7 per cent) of all admissions to home care. Widowed females aged 65 and over (i.e. both the "young elderly" and the "old elderly") who live alone account for one in five of all admissions. Another large group, the "young elderly" who are married and live only with their spouse, accounts for 18 per cent of all admissions. Of this group, just over half (55 per cent) are females.

When clients are admitted to the Manitoba Home Care program, a judgement is made as to the alternative level of institutional care (DALP) that would be required if home care were not available. As described earlier, the DALP ranges from "remaining at home without care" to admission to (or remaining in) "acute hospital care".

Almost one-third (30 per cent) of the adult clients admitted to the program during February and March of 1978 would have remained at home without care, were home care not available; 35 per cent would have been admitted to, or remained in, hospital (half accommodated in acute care and half in non-acute care); and 35 per cent would have been admitted to a personal care home (12 per cent to Level I, 18 per cent to Level II, and five per cent to Level III/IV care).

Demographic characteristics have a significant impact on the DALP. For instance, a majority of young persons were more likely to remain at home without home care services or be admitted to hospital, either acute or non-acute care. Similarly, middle-aged people were more likely to have an alternative of acute hospital care than entering a personal care home, or, to a somewhat lesser extent, of remaining at home without care. On the other hand, both the "young elderly" and the "old elderly" would more likely be placed in personal care homes (at all levels), were home care not available.

The DALP for females is slightly more likely to be "at home without care" and slightly less likely to be "acute hospital care" than in the case of males. There is little sex difference in having a personal care home or non-acute hospital care placement as an alternative to home care.

The sex differences that do occur in DALP appear to be associated with age. Four in 10 males under 65 years of age would have been admitted to acute hospital care, compared to less than one-quarter of females in this age group. Conversely, 37.4 per cent of women between the ages of 19 and 64 would remain at home without care, compared to just over one in four men.

Whether this apparent association of age with differences in DALP by sex is real, or simply a function of marital status, is open to question; married persons are more likely to have a DALP of either remaining at home or non-acute hospital care than people of other marital status. They are also considerably less likely to enter a Level I personal care home (hostel) in the absence of home care. Widowed persons, on the other hand, would have been more likely to enter personal care homes than those of other marital status, but are very much less likely to enter either acute or non-acute hospitals.

If married and widowed clients are further disaggregated by age, widowed persons in the middle aged and "old elderly" groups are more likely to remain at home than married persons, while the converse is true for widows in the "young elderly" group. For both widowed and married persons in the "young elderly" group, the DALP is more likely to be a personal care home than a hospital, although the probability is higher for widowed persons than for married clients. In contrast, among the middle aged, the married clients are more likely to be in hospital than a personal care home, while widowed persons are equally likely to be in either.

It is probable that the de-emphasis on personal care homes among the married clients, as compared to the widowed clients, reflects a difference in living situation. In the case of a married client, except for medical treatment, the person could be cared for by others in the household. Widowed persons, on the other hand, are more likely to live alone and require assistance in household tasks. Thus they would have had to enter the "total environment" living situation of a personal care home, were home care not available.

C. HEALTH CHARACTERISTICS OF PERSONS ADMITTED TO HOME CARE

Seven out of 10 persons admitted to the Manitoba Home Care program in February and March 1978, had more than one diagnosed health problem, with the incidence of multiple diagnoses increasing from the young to the elderly clients. Just over half of the young clients had multiple health problems, compared to 60 per cent of middle-aged and almost three-quarters of the elderly clients. There was virtually no difference in the incidence of multiple problems between the "young elderly" and the "old elderly".

Because neither sex nor marital status has any marked effect upon the incidence of single or multiple diagnoses, these variables will not be discussed further. Age is the primary factor in the differences.

Information on health problems was collected in the form of "primary diagnosis" and "secondary diagnosis", although in a number of cases up to four diagnoses were recorded. Because either the primary or the secondary diagnosis, or both, could be the reason the person was admitted to home care,[9] both diagnoses must be considered together. The distribution of clients by diagnostic category, shown in Table 4, includes both primary and secondary diagnoses. In total, there were 1,834 diagnoses made for 1,167 clients. In other words, there were 667 clients who had a secondary diagnosis.

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[9] Medical diagnosis might not, in fact, be the major reason for admission. A person's personal or social situation could be the main reason for requiring home care, with a health problem only compounding the need.

The most common health problem which accounted for the largest proportion of clients admitted to the home care program was cardiovascular ailments. Musculo-skeletal disorders (mainly arthritis and rheumatism) were the next most prevelant specific health problems, followed closely by cancers and endocrine/metabolic disorders.

There was considerable variation in the kinds of health problems by age group. Degenerative and ill-defined conditions were generally more common among elderly clients, with acute conditions more prevelant among the younger age groups.

TABLE 4

Number and Per Cent of Clients* by Diagnostic Category, and by Age Group

		19-44	45-64	65+		
Diagnostic Category		Young	Middle-Aged	"Young Elderly"	"Old Elderly"	All Ages
Cancers	Number	12	49	91	16	168
	Per Cent	(10.5)	(22.5)	(14.8)	(7.3)	(14.4)
Endocrine/ Metabolic Disorders		10	41	94	24	169
		(8.8)	(18.9)	(15.3)	(10.8)	(14.5)
Mental and Central Nervous System Disorders		26	25	71	25	147
		(22.8)	(11.4)	(11.6)	(11.3)	(12.6)
Cardiovascular		9	76	226	113	404
		(7.9)	(25.7)	(36.9)	(50.9)	(34.6)
Respiratory		8	17	69	33	127
		(7.0)	(7.8)	(11.3)	(14.9)	(10.9)
Musculo-Skeletal		9	32	115	31	184
		(7.9)	(14.7)	(18.8)	(14.0)	(16.1)
Fractures/Injuries		18	27	86	21	152
		(15.8)	(12.4)	(14.0)	(9.5)	(12.6)
Ill-Defined Conditions		6	5	53	38	102
		(5.3)	(2.3)	(8.7)	(17.2)	(8.7)
Surgical-Medical Complications		11	22	40	0	73
		(9.7)	(10.1)	(6.6)	(0.0)	(6.2)
Other		51**	53	142	59	305
		(44.7)**		(24.3)	(23.2)	(26.6)
Total No. of Diagnoses		161	347	987	360	1,834
Average No. of Diagnoses Per Client		1.40	1.50	1.61	1.63	1.57

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*Both primary and secondary diagnoses are counted. Thus the total percentages exceed 100, and the total shown for "all ages" exceeds the total number of clients in the study.

**Note that almost one-third (16 clients) in this category are obstetrical cases, which accounts for 14 per cent of this age group, but are virtually absent from the other age groups.

Since it is not possible to identify the specific health problem necessitating home care, diagnoses were not used as a factor in the analysis of services and costs. For example, client A could have a primary diagnosis of cancer and a secondary diagnosis of arthritis (a musculo-skeletal problem). Client B could have a primary diagnosis of arthritis and a secondary diagnosis of a cardiovascular disorder. If analysis were undertaken of services received by people with arthritis, both clients A and B would have to be considered. Yet the other health problem in either case *may* be the major reason for admission to home care, and, even if this were not so, it could still have a large effect on the type and amount of services received. To analyse kinds and amounts of services by homogeneous groups with regard to health problems (i.e. all and only those with diagnosis x and diagnosis y) would require a sample of much larger size than the one in this study, in order to obtain groups of sufficient size to yield meaningful information.

A third indicator of health status in this study is "prognosis". This may be "rehabilitation" (or recovery), "maintenance at the present level", or "deterioration" of the individual's state of health. Almost half of these clients admitted to home care were expected to be maintained at their present level of health, over one-third were considered able to be rehabilitated, and fewer than one in five were expected to have their condition deteriorate.

The proportion of each age group that will be rehabilitated declines sharply with age. Clients in the middle-aged group (45-64 years) show the largest proportion (23 per cent) of those whose condition is expected to deteriorate. This finding may reflect the onset of degenerative conditions in middle age. Thus, whereas the health of the middle aged may be in the process of decline, that of the elderly groups may already have deteriorated and reached a plateau where it can be expected that its level can be maintained, although this level may be lower than that of younger age groups.

In terms of the designated alternative levels of placement, there is wide variation by the three health factors discussed earlier. People with a single health problem would more likely be either at home without care or in acute hospital care, while those with multiple diagnoses are distributed more proportionately across all alternatives.

This polarization of alternatives for those with single diagnoses is a reflection of the association of age and single or multiple health problems, and of age and the DALP. In general, the proportion of each age group having the DALP as home and/or hospital[10] declines with age, while the proportion having placement in a personal care home increases with age. Differences in single or multiple diagnoses emphasize this association, with the magnitude in differences declining with age.

D. CONCLUSION

Although there were large differences in sex, marital status, living arrangements, diagnosis, prognosis, the incidence of single or multiple health problems, and the designated alternative level of placement among those clients admitted to the Manitoba Home Care program during two months of 1978, each of these factors appeared to be strongly associated with age. Thus, without specifying any causal relationship, age can be used as a summary variable in analysis, since groups tended to be more homogeneous by age for each of these factors than for any other variable.

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[10] Young clients tend to have the DALP as hospital, (acute and non-acute), while middle-aged persons tend to remain at home.

PART III

MAJOR SERVICES RECEIVED BY CLIENTS ON ADMISSION

The most prevalent services designated to be provided in the first month of service for the 1,167 persons admitted to home care were direct nursing for 77.1 per cent of the clients and homemaking for 37.6 per cent. Other services provided were health auxiliary services (Licensed Practical Nurse, aide, orderly) for 9.2 per cent, therapy services for eight per cent, social services for 3.1 per cent, volunteer services for 9.6 per cent, facility services (day care, day hospital) for 2.1 per cent, and supplies services for 16.3 per cent. These percentages are for all adult age groups admitted. It should be kept in mind that this study encompasses intake into short-term care as well as long-term care from all parts of the province and is focussed upon care planned in the first month following admission. Thus, the services required by short-term clients are disproportionately reflected, and these figures are different from those of the full case load of the program. The program statistics[11] for the total Manitoba Home Care case load (including intake case load) for February and March 1978 show that 35 per cent of all clients receiving home care received direct nursing services and 45 per cent received homemaking services.

From the above figures it is obvious that a number of clients, on admission, were receiving at least two or more types of service in the home care program. Table 5 shows selected groups of service types, focussing on combinations involving nursing and homemaking services since these are received by the largest proportions of clients. As noted earlier, the services in the first months after admission are not the same as for the total program case load.

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11. Office of Continuing Care, Program Statistics, February and March, 1978 Tables II (a) and III (a).

TABLE 5

Number and Per Cent of Clients Receiving Selected Combinations of
Types of Service in the
First Month After Admission

Types of Service	Number of Clients	Per Cent
Nursing Services Only	350	30.0
Nursing and Homemaking, plus Other Types	273	23.4
Nursing and Supplies Services Only	152	13.0
Nursing plus Other Types (No Homemaking)	125	10.7
Homemaking Services Only	101	8.7
Other Types of Services (No Nursing or Homemaking)	101	8.7
Homemaking plus Other Types (No Nursing)	65	5.6
Total	1,167	100.0

When the study findings of the distribution of nursing services and homemaking services designated for those admitted were examined by age groupings, it was found that the heaviest consumers of direct nursing were the middle-aged (45-64) category where 84.9 per cent received direct nursing care. In contrast, the percentages of the young, the "young elderly", and the "old elderly" identified as receiving nursing service were 78.1 per cent, 74.9 per cent and 75.2 per cent respectively. With homemaking service, 41.6 per cent of the "young elderly" and 43.2 per cent of the "old elderly" received this service, but only 31.6 per cent of the young and 23.9 per cent of the middle-aged clients did so.

PART IV

COST "SAVINGS" FROM HOME CARE, COMPARED TO COSTS OF DESIGNATED ALTERNATIVE LEVELS OF PLACEMENT

The cost of the designated alternative level of placement for each client, as used in this report, is the imputed monthly cost of care in the designated institution located in the client's geographic area. For example, the median cost of placement in a personal care home, Level II, would be $504.00 for a month (30 days) in Winnipeg Region, but $965.50 in Thompson Region. The costs of the DALP were calculated for each client, and then aggregated to form the total cost for all clients. Cost savings were also calculated on a per client basis, with the total cost of home care subtracted from the cost of the DALP for each client. These figures were then aggregated to determine total savings, or savings within specified groups.

It should be noted that when a case was designated specifically as receiving services for less than one month, the cost of the DALP was adjusted to account for the number of days that home care was actually received.

The costs used in this analysis represent costs to the "state" -- that is, paid for through health insurance, public treasury funds, etc. -- rather than costs to the client. Thus, for clients whose DALP was "remaining at home without care", there was a nil cost assigned.[12]

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12. The number of clients whose DALP is institutional care and who would be receiving social assistance (the cost of which is not included in the cost of home care) while on home care, is not large. It should, however, be noted that for the purposes of the study, the cost for food and lodging at home was assumed to be equal to the per diem charge to the client for room and board in an institution. Where clients actually were in receipt of social assistance, payments would be continued regardless of whether care was being given at home or in an institution. Thus the assigned "nil cost" is appropriate for the purposes of this report.

The total cost of providing home care for the 1,167 persons in the study for the first month was $188,000. If each of these clients had instead been placed in their designated alternative level of placement, the total cost of providing care for one month[13] would have been $1,382,000. Thus the provision of home care rather than placement in an institution, even in those cases where home care was provided but where no alternative institutional placement would have occurred, represented a total saving of $1,193,000 for one month in terms of these clients.

Table 6 shows the average cost of one month (30 days) in each level of designated alternative placement, and compares this to the average total cost of providing home care services to clients for each DALP.

TABLE 6

Average Cost of One Month in Alternative Levels of Placement, and for One Month of Home Care Services, by DALP

DALP	Average Cost of DALP for One Month	Average Total Cost of Home Care for One Month	Difference in Average Costs
Remain in Own Home Without Care	$ 0	$ 93	$ -93
Personal Care Home Level I (Hostel)	399	98	301
Personal Care Home Level II	524	186	338
Personal Care Home Level III/IV	805	249	556
Non-Acute Hospital	1,744	189	1,555
Acute Hospital	4,012	244	3,768
Weighted Averages	1,184	161	1,023

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13. Or for the period equal to the number of days on home care by those persons who received it for less than one month, as discussed earlier.

The study showed that the average cost of providing home care services was considerably less than the average cost of institutional placement would have been for those clients who would have been so placed if home care had not been available. As expected, the differences in costs increased significantly with the higher levels of DALP.

Of the 1,167 clients admitted to the home care program in the study, 822 would have been placed in an institution or remained in hospital, had home care not been available. For the 345 persons who would have remained at home, the cost of home care is, by definition,[14] more expensive than the alternative. Of those who would have been institutionalized, home care is less expensive than the DALP for 97 per cent of them. For the remaining 24 clients, nine were specifically short-term care (i.e. services were delivered for less than one month), three had a prognosis of deterioration, and for 12 clients, the prognosis was "maintenance at present level of health status". Since costs of home care usually decline after the first month or so on the program, due to fewer services being required, it is feasible that for most of the 24 clients who remained on the program, the cost of home care would eventually be less than the cost of the DALP.

Excluding those who would "remain at home", the largest proportion of persons for whom home care is more expensive would be in a personal care home, Level II. As a general rule, home care costs are not to exceed costs of the DALP in the Manitoba Home Care program, except for short-term acute episodes or for terminal illness, or for those on the priority list for personal care home placement.

The relatively few people for whom the DALP is PCH-Level III/IV may indicate that persons with this DALP at admission require an amount or kinds of services greater than can be appropriately sustained on home care. In most such cases the individual would have been placed in a PCH - Level III/IV, rather than receive home care. This may also suggest that most persons are admitted to home care in Manitoba before their DALP reaches Level III/IV. A study of the DALP levels of the total home care case load would be required before this could be clarified.

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[14] That is, the cost of the DALP for these people is nil.

The savings from home care (that is, the cost of the DALP minus the cost of home care, per client) ranged from -\$1,601[15] to \$3,994. "Negative savings from home care" were produced when the home care cost was greater than the cost of the DALP. Thus, in fact, there were no "savings" as such, but a net cost. As would be expected the size of savings increased as the DALP increased, although the ranges of savings within each DALP varied widely. This is indicated in Table 7.

TABLE 7

Largest, Smallest, and Average Monthly* Saving Per Client
from Home Care, by DALP

DALP	Largest Saving	Smallest Saving	Average Saving
Remain at Home, No Care	\$ -1	\$ -1,601**	\$ -93
PCH - Level I (hostel)	485	-434	300
PCH - Level II	960	-567	338
PCH - Level III/IV	884	-327	556
Non-Acute Hospital	2,469	-191	1,555
Acute Hospital	3,994	3,389	3,768
Weighted Average			1,022

*30 days
**See footnote 15

Although ranges of savings within each DALP were large, it was found that when they were grouped into quartiles the savings resulting from home care tended to cluster for each level of DALP. For example, home care savings for three-quarters of all persons whose DALP was "remain at home" fell into the lowest quartile, while savings for all persons whose DALP was "acute hospital" fell into the fourth quartile. Table 8 illustrates this clustering.

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15. Note that this large negative saving is for one isolated and exceptional case where illness and a "crisis" social situation required an unusual level of service. The next smallest negative saving was about -\$800, and was more typical of the lower limit of the range.

TABLE 8

Number and Per Cent of Clients with "Savings" from Home Care, by Quartile Grouping, and by DALP

(% are row %)

DALP	First Quartile (-$1,601 to -$39)		Second Quartile (-$38 to $420)		Third Quartile ($421 to $1,576)		Fourth Quartile ($1,577 to $3,994)	
	No.	%	No.	%	No.	%	No.	%
Remain at Home	267	77.4	78	22.6	0	0.0	0	0.0
PCH - Level I (hostel)	2	1.4	92	64.3	49	34.3	0	0.0
PCH - Level II	17	8.1	103	48.9	91	43.1	0	0.0
PCH - Level III/IV	1	1.8	14	24.6	42	73.7	0	0.0
Non-Acute Hospital	1	0.5	7	3.3	111	52.3	93	43.9
Acute Hospital	0	0.0	0	0.0	0	0.0	199	100.0

Analysis showed that the DALP was associated with both the types of services received and the age of clients (with these latter two factors also associated). Therefore the clustering of home care savings by DALP would suggest that there would be differences in savings by both types of services and by age.

Only five per cent of the clients for whom savings from home care fell into the fourth quartile did not receive nursing services, compared to almost 20 per cent of clients for whom savings fell into the first quartile. With regard to homemaking services, almost two-thirds of the clients with savings in the second quartile received homemaking services, compared to one in three clients in the first quartile, and one in four in the fourth quartile. In general, clients for whom savings from home care fell at either the high or low end of the range of savings were more likely to receive nursing services, while clients whose home care savings fell in the middle range were more likely to receive homemaking services.

Because so many home care programs offering long-term care tend to focus on, or be restricted to, providing services to elderly clients, it is useful to examine briefly the savings from home care by age groups. Table 9 shows both the average and total savings represented by home care, compared to the cost of the DALP, for each age group.

TABLE 9

Average Savings Per Client and Total Savings Resulting from Home Care, by Age Group

Age Group	No. of Clients	Average Saving in First Month from Home Care	Total Savings in First Month from Home Care
Young	114	$ 1,526	$ 173,979
Middle-Aged	218	1,448	315,748
"Young Elderly"	613	938	574,880
"Old Elderly"	222	579	128,623
All Ages	1,167	$ 1,022*	$ 1,193,230

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*Weighted average.

Although the average savings in one month from home care per client declined with age, the total savings per age group increased with age. This is due to the higher propensity for elderly persons to require home care, with their consequent much larger share of total admissions. Thus, on a per client basis, the positive financial gain from home care is much higher for those persons under 65. When, however, the overall costs of providing services are considered, home care services for elderly persons will save the greatest number of health/social service dollars.

It is also useful to view the situation from another angle. Short-term care, especially when the alternative was "hospital" (acute or non-acute), tended to be concentrated in the younger age groups where savings per client for one month were greatest. Therefore, it could be speculated that if duration of care were considered, the total savings per client would be greater for the older age groups.

PART V

CONCLUSIONS

This study has examined the characteristics of home care clientele in terms of demographics, social situation, and health; the services received by clients on admission to the home care program during their first month; and finally, the costs and cost-savings of home care for the first month of service as compared to the designated alternative level of placement in institutional care for one month. Some major conclusions have been reached.

The propensity to need and to use home care services increases sharply with age. Almost three-quarters of the home care clients were aged 65 and over; slightly more than one-quarter of these were among the "old elderly" (males aged 80 and over; females aged 85 and over).

Highly significant is the fact that even though home care at admission for about one client in three, including those who would have remained at home without care, is more costly than the designated alternative level of placement, the cost saving of a comprehensive, universal home care program of the "Manitoba-type" can be substantial. This conclusion is even more striking in that this study was restricted to the highest cost period for home care service, that is, the first month of service.

While many analysts discuss the desirability of programs designed primarily for elderly persons, this study showed the greatest cost savings per client to be among the younger age groups. The large number of clients aged 65 and over, however, results in a greater total cost saving for the elderly than the non-elderly clients.

Finally, "Manitoba-type" home care programs represent one means of reducing the costs of health care. Presently the population aged 65 and over represents about nine per cent of the total population. This is expected to increase to about 20 per cent in 2031 when the post-war baby boom reaches its mid-sixties. This aging of the population suggests that home care programs will likely become an increasingly important part of the overall health and social services delivery system.

APPENDIX 3

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LONG-TERM CARE: AMERICAN PROBLEMS AND FOREIGN SOLUTIONS

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Prepared for the Select Committee on Aging
United States House of Representatives
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Long-term care of the elderly baffles every developed country at present. America's problems are universal. Sharing experiences across countries reveals a number of suggestive approaches abroad that the United States might emulate. But America has been quite inventive as well, and sharing enables other countries to learn too.

Following are some impressions of how other developed countries have tried to solve the problems of long-term care of the elderly. The discussion is brief, since I have not yet performed thorough field research abroad about long-term care. Rather, it is a by-product of my earlier research in Europe and North America about the organization and financing of acute care. (I summarized foreign experiences in acute care and lessons for the United States a year ago in testimony before the Select Committee on Aging, included in International Perspectives on Health Care: Learning from Other Nations, 1 May 1984, Comm. Pub. No. 98-450). I hope to devote more attention to long-term care abroad in forthcoming research.

NATIONAL STYLES

Care of the elderly traditionally has been the responsibility of families and churches, often working together closely. They covered the full range of needs in housing, nutrition, personal service, health care, and so on. If the elderly person lacked a family and if the churches had developed no services, money or services were provided,usually by municipal welfare offices and occasionally by non-religious charities.

No country has developed a nationwide system covering all components of long-term care. Every country has a great mixture of categorical programs, usually with gaps for some needs. Every country has great regional variations in provision, with many more services in the principal cities than in the less conspicuous areas. My previous paper for the Committee about health services could present simple generalizations; but because of the heterogeneous nature of long-term care abroad, this paper is more intricate.

Acute medical care has evolved quite differently. Most European countries have statutory health insurance as part of the social security system. It began with coverage for the younger workers and their families. The elderly were added after World War II. Payroll taxes, benefits, methods of paying doctors, and methods of paying hospitals became standard for nearly the entire population of each country including the elderly. Health services spread throughout every region. But the non-acute long-term care benefit package, financing, and services are not standardized and universally available.

A few developed countries have universal entitlement of acute health care through general revenue (Great Britain and Canada), but these arrangements are unusual. The British national government not only pays for acute care but delivers it through hospitals, health centers, and community programs. Since the entire population has access to acute care, all elderly are automatically entitled. But full long-term care benefits are not yet included.

AMERICA'S PROBLEMS

The universal problems of long-term care exist in the United States, some more and others less serious:

*Availability of the full range of benefits: acute health care, nursing care for the chronically ill; appropriate housing with health and social supports; home services in health, nursing, homemaking, and meals; recreation.

*Provision of the services in adequate amounts in every community.

*Whether ownership and management should be religious or secular, public or private, for-profit or nonprofit.

*Quality of the staffs.

*Coordination of the services so the individual can obtain the right mix when needed. Satisfactory variation in use over a lifetime.

*Case management to represent the individual's interests, obtain cost-effective services, explain the complexities.

*Financing: mix of insurance, general revenue, the individual's pension, the individual's property, the family's resources.

*Cost containment: prevention of waste, overcharging, excessively elaborate services.

*Role of the individual's family: relations with community organizations, their financial contribution, respite help.

AVAILABILITY OF SERVICES

There is a growing number of books and articles describing health and social services for the elderly abroad. The reports imply that these programs are plentiful, widely used, harmonious in administration, and lacking any venality. To weary Americans, the elderly seem better off anywhere else. But we need thorough research about the number and distribution of these services in each country, the ease of access by those in need, the costs, and the benefits. On close inspection, no country has all services in adequate supply and in the right locations. Every policy involves tradeoffs: both cost containment and generosity cause problems.

Acute health care services: Every developed country covers all the elderly in mainstream acute care by adding them to the national health insurance (NHI) systems earlier designed for the employed and their dependents. The procedure is identical for young and old: the patient goes to his/her regular doctor, to the hospital upon the family physician's referrals, and the sickness fund pays in full with no or little patient cost-sharing. Prescription drugs and other medical devices are covered for both young and old, usually with copayments.

Coverage of the retired is simply an extension of the obligatory health insurance systems that have existed in Europe for over a half century. Every person has had this coverage throughout his/her working life, and the same coverage continues. No country began national health insurance with the elderly first, as did the United States under Medicare. No country gives the elderly better acute care coverage than the young, as does Medicare.

Universal acute care coverage has long been provided the elderly in Britain and in Canada without waiting for the extension of obligatory health insurance. Acute health care services are paid for by general tax revenue. All inhabitants (old and young) automatically received full entitlement upon enactment of the law--in Britain in 1948; in Canada for hospital care in all provinces during the 1950's; in Canada for physicians' care in all provinces during the 1960's. Prescription drugs and medical devices are covered in Britain's NHS, with copayments for adults but no copayments for the elderly. Most Canadian provinces provide prescription drugs for the elderly without copayments; a few others require small cost-sharing. In most of Canada, the drug benefits are confined to the elderly.

Extended-care hospitals: Once European nonprofit and municipal hospitals mixed everyone together. They housed the homeless, including the ill young and the infirm elderly. Stays were very long. Not until the late nineteenth century did European countries distinguish between the old-age home for the infirm and the short-stay acute hospital for those who would recover quickly and return to jobs and families.

As populations aged during the twentieth century, acute hospital beds were filled by elderly with chronic disabilities: they could not live in old-age homes or with their families, but they filled space intended for high-tech acute care on the curable. After World War II, several countries created extended-care hospitals, primarily (but not exclusively) for the long-stay elderly. They resemble American SNF's. The country that has practiced hospital regionalization most extensively (France) has many examples of triumvirates under common management, viz., the short-stay acute hospital (hôpital), the extended-care hospital (hôpital de longue durée), and the old-age home for the infirm (hospice). When the nineteenth century hospital building was replaced by a modern one after World War II, often the old one became the extended-care facility. Patients can be referred back and forth efficiently, according to their needs.

No country--not even France--has such a system everywhere. A few have retained the older tradition of mixing long-stay and short-stay patients in the same wards. Germany has some extended-care hospitals, but many chronically ill elderly fill the beds in acute-care hospitals, resulting in very long average length of stay and a very high ratio of hospital beds to population. Since hospitals are paid by average daily charges calculated across all patients, the elderly may be in excessively expensive settings and may be managed in ways not appropriate to their needs. Because of the long stays and high occupancy, Germany cannot reduce its excessive number of beds.

No country has the resources to spread extended-care hospitals everywhere. Therefore, in French towns, the long-stay elderly fill up the beds in the local acute hospitals. France concentrates its acute-care resources in larger cities.

Nursing homes: They exist in every developed country, but the countries vary in numbers, patterns of ownership, and quality. National health insurance covers acute- and extended care hospitalization but (except in Holland) not nursing homes. Without such massive financing of use, nursing home sectors developed in limited numbers and often must stint in amenities and staffing. Because Medicaid money is available, America may have more nursing homes than most European countries. Without the standardization of benefits and of provider eligibility criteria under national health insurance, nursing home characteristics in every country vary widely.

Nursing homes are not part of Britain's National Health Service: the NHS does not pay institutional providers, owns and manages all services itself, runs a few institutions for the mentally handicapped (inherited from pre-NHS local authorities), but has never become committed to general nursing home care. Many private nursing homes exist in Britain; they are heterogeneous and patients pay privately.

Hospitalization under NHI does not run forever. After a fixed number of days--perhaps several hundred, with the number varying among countries--coverage expires. A patient may stay in the extended care facility or go to a nursing home--both at his/her own expense or with the help of the municipality's public welfare office.

Holland alone has extended NHI to nursing homes, by means of a special health insurance program (the General Law for Exceptional Medical Expenses or AWBZ). It is funded by additional social security payroll taxes paid by all employers on their entire payroll up to an earnings ceiling. NHI pays for hospitalization up to one year, and AWBZ covers all costs for patients thereafter, in either extended care hospitals or nursing homes. The principal beneficiaries have been the elderly and mentally handicapped. Universal coverage of the entire population has resulted in a more extensive spread of nursing homes than in any other country. Because AWBZ covers full operating costs, including amortization of debt for the original construction, and because provider eligibility standards are high, the amenities and staffing in Dutch nursing homes are very generous.

Several Canadian provinces during the 1970's added payment to nursing homes, to supplement the earlier coverage of the elderly and of everyone else for acute care by hospitals and doctors. As in the case of acute care, any citizen needing the service is fully entitled. The provincial Ministry of Health pays the nursing home for a large share of the patient's costs. (I do not know the effects on the number, geographical distribution, and quality of nursing homes in Canada.)

Home care. Several countries have had home care programs for centuries, often run by religious associations. An example is France. If a patient lacked a home or burdened the family, he/she was admitted to the hospital. Otherwise, the religious nursing order, the general practitioner, and the midwife, made home visits. These programs were originally intended to help the recovery of workers and their wives, rather than provide long-term support for the elderly.

Home care included social supports as well as acute treatment. In particular, when the wife was incapacitated from illness or from a difficult delivery, someone had to cook and care for the children.

Substantial home care programs developed in Britain and Scandinavia to compensate for the great shortage of hospital beds. Municipalities and private nonprofit associations employed professionally trained public health nurses and domestics. British practices were copied in the United States.

As the young improved in health and were treated in physicians' offices and in hospitals, the original purposes of home care disappeared. Services in several countries (such as France) languished. But as medicine progressed, more infirm elderly needed care. Countries with substantial home care programs -- particularly Britain, Holland, Denmark, and Sweden -- reoriented home care toward the elderly, emphasizing home-help services, meals-on-wheels, and personal nursing care. Growing resources and personnel are devoted to home care services in general and the non-medical components in particular, because of widespread public policies to reduce hospital beds and because of strong social policies (not merely health policies) by governments (as in Britain and Scandinavia) or by religous movements (as in Holland).

Several other European countries have recently encouraged home care programs, as they try to reduce hospital overbedding and place the elderly in more humane settings. For example, France now begins a resurrection,expansion,and modernization of its home care tradition, while Germany tries to create a new system with little previous experience.

Congregate housing is common in some countries and rare elsewhere. It exists where governments or religious associations have a strong commitment to social benefits. Extensive development is possible where municipal governments dominate residential housing through regulation of land use and construction of multi-unit buildings, as in Scandinavia and Britain. It also depends on a well-developed home health care system to deliver health and social services.

Holland also has a number of congregate housing units created and managed by religious associations and municipalities. The residents have usually been members of the sponsors' denominations. A purpose of congregate housing efforts in Holland and Scandinavia is to keep the elderly in the community, rather than to isolate them in traditional old-age homes.

However, many countries lack extensive housing for the elderly, aside from occasional private business ventures. The barriers to extensive congregate housing are the absence of a public social policy and reliance on private enterprise for housing. Even in countries with substantial congregate housing, the establishments cluster in the large cities and are absent from the towns. In many countries, the elderly predominate in these towns: the young migrated to cities, and many persons return to their families' houses after retirement.

OWNERSHIP, MANAGEMENT, AND COORDINATION

A problem in American long-term care is the diversity of owners and managers, and the lack of coordination among them. A patient might need several services, but they are delivered by different vendors. If a patient needs referral from one type of service to another, because of a deterioration in his/her condition, the referral often must be made between two vendors who do not customarily cooperate.

While most American hospitals are owned and managed by nonprofit associations and local governments, the long-term care sector is quite different. Most nursing homes, home care agencies, and congregate housing sponsors ("life care communities") are private business firms that share the American private economy's philosophy of earning high profits, letting customers protect themselves by shopping among competitors, and disclosing as little as possible. For-profit nursing homes are accused of maximizing profits by underservicing and by fraudulent billing of Medicaid. National and state governments have responded by elaborate regulation and inspections, often hamstrung by the sheer magnitude of the task, by litigation, and by the American presumption on behalf of free private transactions. Some states have postponed a solution by blocking new nursing home construction -- despite waiting lists -- and by hoping that home care will fill the need.

As other parts of the American long-term sector grow, the numbers of for-profit private owners increase. The first home-care programs in the Northeast were nonprofit and managed by dedicated people, but there are some anxieties about possible underservicing by the many for-profit vendors starting everywhere.

Most American life-care communities are private real-estate developments, with all the hazards of private enterprise including (in some countries) overestimates of the demand, underestimates of the operating costs, and bankruptcies. As in all private real estate investments, it is the buyers (i.e., the dependent elderly) who face risks as well as the original promoters.

Extended-care hospitals are licensed, managed, monitored, and paid like the acute care hospitals of each country. Ownership and management can be predominantly nonprofit or municipal, depending on the country's general pattern. In some countries, a number of extended-care hospitals are for-profit enterprises by doctors, but usually private clinics are for acute care since physicians find chronic care less profitable and less interesting clinically.

A country's health insurance system can prevent for-profit hospitals from existing, by refusing to pay them. By this method, all Dutch acute and extended care hospitals are nonprofit or municipal.

Extended-care hospitals are monitored closely in Europe -- regardless of whether they are for-profit, nonprofit, or municipal -- since they depend on national health insurance and follow the same payment procedures as the acute hospitals. They must submit prospective budgets to the sickness funds in rate negotiations (in Germany and Holland) or to the rate regulators (in Holland and Switzerland). Their costs are covered in full, they cannot earn profits, and they gain nothing from underservicing. (Municipal and nonprofit extended-care hospitals are also screened by rate regulators in France but French for-profit hospitals are paid differently.)

In some European countries, particularly France, an extended-care hospital is under the same nonprofit or municipal ownership as the community's acute hospital. In a few countries like Germany, religious associations own and manage chains of extended-care and acute-care hospitals.

Nursing homes are a different matter. In many countries, they are predominantly for-profit private businesses, as in the United States. Similar problems arise. If one hears little about abuses by for-profit nursing homes, often it is because a country has few nursing homes of any kind.

Holland's nursing homes were created by nonprofit (usually religious) associations and by municipalities, most in a short period during the 1970's, just after the enactment of AWBZ. Costs are covered in full by a daily charge, set by a procedure that also applies to acute hospitals under NHI, viz., preliminary negotiations between the local sickness funds (who administer AWBZ money) and the nursing home; and final rate-setting by a national commission, both steps based on a careful screening of the nursing home's prospective budget by the sickness fund and commission. The problem has not been underservicing, since the nursing home is guaranteed all its costs, its management is usually religious, and its performance is scrutinized by payers and regulators. The problem has been overservicing, since the nursing homes were built during a euphoric period and their operating costs -- guaranteed in full under AWBZ -- have been very high. In order to control costs, avoid excessive institutionalization, and avoid construction of more nursing homes, Holland has tried to cope with growing demand by encouraging the existing nursing homes to add day care programs.

In other countries, ownership is usually a mixture of nonprofit and for-profit. Transactions with patients are usually direct and unregulated, since a public reimbursement system is not directly involved. Because of the centuries-long special interest by churches in the elderly, many nursing homes are owned, managed, and staffed by religious orders. The diminishing numbers of Catholic nursing nuns and Protestant Deaconesses have disappeared from the hospitals of Germany, Switzerland, and other European countries but still work in the orders' nursing homes.

All nursing homes in Great Britain are private, since nursing home care is not a reimbursed benefit or a directly provided service of the National Health Service. Some of the 1200 nursing homes are nonprofits, owned by churches or by the respected nonprofit chain, the Nuffield Nursing Homes Trust. Most others are independent and are owned and managed for profit, often by persons from a background in real estate, as in the United States. All nursing homes must register with the Department of Health and Social Security, but oversight and sanctions for underservicing hardly exist, since no standards are prescribed by law. Quality of care depends on the conscience of management and the vigilance of the patient, since the transaction is private.

Home care. Where it exists in Europe, home care is a major program, managed by nurses and by social workers. Doctors in general practice participate but do not manage it. The social supports and household help have always been considered at least as important as the medical components.

For decades in Britain before creation of the National Health Service, home care was conducted by charitable associations and by municipal governments. It has now become one of the tasks of the District Health Authorities of the NHS. The District Nursing Officer heads the nursing staffs in both the hospitals and home care.

As in Britain, home visiting has a long history in Scandinavia, antedating the rise of technically-advanced hospital-based medicine. Social benefit programs have been steadily expanded since World War II, delivery is administered by local governments, and therefore they employ the public health nurses and home helpers who do the home visiting. While GP's provide medical home visits in Britain (now less often than in the past), Sweden and Norway have never had enough doctors for adequate office practice, and therefore the public health nurses give a considerable amount of medical care.

Home care in Holland today, as in the past, is a task of the Cross Associations, which are nonprofit religious associations. A few nursing homes offer their own home visiting, but this is not common. A considerable number of Dutch nursing home patients can be discharged, because Cross Associations operate home care programs throughout the country.

Congregate housing. Great Britain, Sweden, and Denmark have built much of their urban residential housing through the municipalities. Included are the special facilities for the elderly. The social service departments of the local government also staff and finance the special nutritional, recreational, and other programs for the elderly residents.

In Holland, some of this housing is created and staffed by local governments, and some by religious groups.

A few special establishments are created by municipalities and religious associations elsewhere, but usually housing is developed by private business. Congregate housing therefore is produced by private firms or by no one. The French government encourages private developers by offering loans and tax breaks.

Coordination. Every country has a mixture of services and gaps, with a mixture of different owners and managers. Coordinating and filling gaps in long-term care require strategic planning for an entire country, and few countries think this way. One that does is France. For fifteen years, it has both written and implemented plans to regionalize acute-care hospitals, their heavy equipment, and extended-care hospitals. (In contrast, most countries -- including the United States -- have very limited and often ineffective plans focussing entirely on where to build new hospitals.) French acute-care and extended-care hospitals are usually coordinated under the same governing board and management, responsible to the local government. Now the Ministry of Social Affairs is developing new plans that will include an appropriate distribution of home care services, and it encourages hospitals -- through grants and reimbursement regulators -- to add home care. Then the acute-care hospital, extended-care hospital, hospice, and home care program will be under common management.

One might think that, if all services are owned by "the government", coordination is easy. But different departments of the same government usually compete as vigorously as private managers do. During the first decade of Britain's NHS, the general practitioners, hospitals, home care, and congregate housing were responsible to different agencies of government. One reason for a general reorganization of the NHS in 1974 was to coordinate hospitals and all community health services under common management.

In most countries, continuity between ambulatory and hospital care is hindered by the medical staff structure. The GP must refer the patient to the hospital specialists and does not see him/her until discharge. Then the hospital doctor may never see the patient again. GP's and hospital doctors usually communicate at arm's length. Family doctors treat patients in hospitals and achieve continuity only in small European towns and in European private clinics. The open medical staffs of Canada and the United States are unusual but have the advantage of promoting continuity.

The elderly person's GP can follow the patient more successfully in other settings. GP's can easily see patients in nursing homes, since the homes don't have closed medical staffs. In Britain and Holland, every citizen is on the list of a GP. But the patient may lose this permanent GP if he/she must enter a distant nursing home. The new GP may be less conscientious.

British and Dutch GP's usually participate actively in home care and usually cooperate well with public health nurses. They have always been expected to be colleagues. The nurse making home visits has long been a respected part of British and Dutch health care. But collaboration depends on personalities and doubtless is not always perfect. Britain's NHS at times has tried to coordinate them further by persuading both to work out of health centers, but GP's have resisted the loss of autonomy.

Vertical integration. The United States recently has developed investor-owned "multi-health care corporation" that own and operate several services. In some communities, large chains (such as Humana) have created the full range of services -- acute hospital, nursing home, home health care, and ambulatory center -- prepaid by insurance. A viable for-profit system might even add congregate housing.

Few private chains exist abroad. For-profit providers usually own one type of service, and nearly all own one establishment. Whether the vertically integrated chains can survive in America and provide satisfactory service -- let alone whether it can be a model for any other country -- remains to be seen.

APPROPRIATE MIXES OF SERVICES

During the nineteenth century, health care in hospitals and in community programs was a mixture of medicine and social services. Successful therapy led to great expansion on the medical side in facilities, personnel, financing, and political power. Health insurance became an important conduit of society's resources, paying a growing number of doctors and hospitals, covering in full the costs of accelerating technical advance.

Americans have misgivings about the possible over-medicalization of long-term care. Medicare has been modelled after acute-care health insurance for the young. Its acute-care benefits are used generously, but perhaps excessively: should so many cardiac pacemakers be installed, should America have by far the world's highest rate of surgery on the elderly? Since Medicare benefits cannot be provided except for acute medical need, some (such as home help) are prescribed falsely by doctors and public health nurses in order to satisfy elderly persons' social needs.

Adding social benefits. Several years ago it appeared as if American Medicare might be extended into long-term care, through higher payroll taxes and additional benefits, both medical and social. But before specific arrangements could be designed, the policy priority became containment of Medicare's acute-care expenditures. Expansion of benefits and of spending has been shelved.

Several countries have added long-term care to existing health and social programs without making compensating cuts elsewhere:

* Holland added long-term care (AWBZ) to NHI:
* Canada added nursing home grants and home care grants to its system of provincial grants to institutional providers in acute care.
* Scandinavia increased home social services to the elderly by increasing the social services staffs of local governments.

Other countries with NHI have avoided Holland's lead. As in the American attitude toward Medicare, the European policy priority for a decade has been to control the growth in acute-care spending (particularly for the hospitals) and to stop the increase in the payroll taxes (for NHI and pensions). The elderly are deemed the source of the higher acute-care spending, and Ministries of Finance have opposed adding another of their open-ended demand-driven benefits to social security. The burden on the economy is more serious in Europe than in the United States, because the dependency ratio is less favorable.

Reallocation. Another option in America is to redirect Medicare away from its acute-care orientation: long-term care benefits would be added, acute-care benefits would be cut, and the change would be "budget-neutral." No country has rewritten NHI in this fashion. NHI was designed for the acute-care needs of the younger workers, the elderly were admitted to the same benefits later, and no country would cut benefits for the population generally just to add non-acute benefits for the elderly.

Nor has any country considered reducing the earlier decision to give the elderly full mainstream acute-care benefits. In fact, they are usually treated more generously than other NHI subscribers, with lower premiums and lower cost-sharing.

Since an NHS administers all services and does not only pay for them, it might cut acute care in order to expand long-term care. The British Department of Health and Social Security for the last decade has sent memoranda recommending that the District Health Authorities reallocate many resources from the hospitals to "Cinderella Services", including special care for the elderly. Hospitals have been reduced in number, but primarily because of general cost containment over the NHS. Further cuts, reallocation to the "Cinderella Services," and the earmarking of growth money to the "Cinderella Services" have not been made as conscientiously as the Department had hoped, in large part because of resistance by the hospital doctors and the hospital workers. The new policy of appointing managers at every level of the NHS is intended to implement the priorities of the Department by such reallocations.

Countries paying for services by general revenue might reallocate from acute-care to long-term care by redirecting their spending. But if they are obligated to cover the acute care prescribed by doctors, the grants can be only voluntary incentives. For example, Canada during the late 1970's tried to build up home care, in the hope that utilization of acute-care hospitals and of nursing homes would diminish. The elderly would be treated in more congenial settings, and government would save money. The national government encouraged provincial programs by making block grants to the provinces. So far, home care seems to have used additional resources without reducing admissions or stays in hospitals and nursing homes.

Orientation of doctors. A universal problem is the medical profession's preoccupation with technically advanced acute care, its disinterest in long-term care of the elderly. In all countries, education, the payment system, and professional recognition reward diagnosis and cures by technical interventions.

Interest in primary care, geriatrics, and home visits has been preserved in a few countries -- particularly Great Britain and The Netherlands -- because the medical profession and the general public retain a high respect for general practice. In both countries, the official schemes (the British NHS and Dutch NHI) pay the GP's by capitation fees and not by fee-for-service. The patient cannot bypass the GP and go directly to the specialist under the official scheme but must be referred by the GP.

Understanding of the elderly patient is being promoted in several British medical schools by making geriatrics part of the required curricula. But this attempt to redefine medical practice is nearly unique to Britain.

CASE MANAGEMENT

America in health as in other sectors presumes that the individual looks after himself/herself, shopping and bargaining to satisfy his/her preferences in the most cost-effective manner. But understanding the long-term care scene would baffle anyone. If the older person lacks a conscientious family member, he/she can easily be cheated or abused by a provider. After entering a nursing home, the individual may lose contact with the former family doctor and with the home visitor, who provided some guidance before institutionalization.

Individual case managers: Extramural programs for the elderly in Scandinavia are defined primarily as social rather than medical, and the elderly applicant is guided throughout by a social caseworker. (I do not know how this works in practice. Perhaps the caseworker becomes active after the person requests a service, instead of being involved earlier in the diagnosis of needs.)

The general medical practitioner is supposed to be the case manager in the health sectors of Britain and Holland. Every British citizen and Dutch insurance subscriber throughout his/her life is entitled to be entered on the list of a G.P. GP's tend to lose track of their patients during hospitalization and the same might be true in practice during institutionalization in a nursing home, although conscientious GP's continue to see their patients there. GP's cannot devote too much time to one patient--despite the extra capitation fees for the elderly--since they have thousands of others on each list. GP's probably can provide only perfunctory advice and referrals to the home visitors for the elderly patients' numerous non-medical problems, involving pensions, housing, and home service.

Social HMO's. The United States has developed an ingenious solution to the multiple problems of coordination between medical and social services, availabiiity of the full range of services to the individual in need, protective case management, and predictable costs. A virtue of the unstandardized--and often tumultuous--American system is the ability to produce such innovations.

Once many European countries organized their sickness funds as prepaid closed panels that tied their subscribers to services provided by the funds themselves. Some went beyond acute health care and delivered home services for the disabled and orphaned, widows' benefits, and so on. They were oriented toward the younger workers, since elderly members were few. The enactment of NHI and of local government welfare programs transformed these funds: the NHI laws guaranteed free choices among all doctors and all patients, a particular fund no longer employed its own doctors, and subscribers could not be compelled to use that panel; most funds no longer provided home care and other social services. Therefore, the potential for evolution into Social HMO's for the elderly disappeared in most of Europe.

However, not everywhere. In France and Belgium, the sociétés mutuelles survive, partly as carriers to pay independent doctors and hospitals and partly as prepaid service providers employing physicians, dentists, pharmacists, social workers, etc. Subscribers can use these services with none or less of the cost-sharing required by the general NHI.

HMO's--and particularly Social HMO's for the vulnerable elderly--are an area of potential American lessons for Europe. French journals have begun to publish proposals for RSC's (réseaux de soins coordonnés) in health, inspired by the American HMO. The société mutuelle and the Social HMO could be synthesized as a manager-provider for long-term care of the elderly in many countries.

FINANCING

Originally, services for the elderly were purchased by the individual and the family, provided by charitable religious associations, or (for the indigent) provided by local governments. Traditional financing of acute care for the entire population in all developed countries was transformed years ago. Comparable transformation of long-term care financing did not occur when it might have during the 1970's, because of widespread anxieties over the costs of acute care and pensions. Therefore, in most countries, financing of long-term care remains fragmented.

Insurance. The Netherlands is the only country to enact long-term care insurance for an entire population. AWBZ is part of the social security system with a payroll tax paid entirely by the employers. It pays for inpatient nursing-home care; for nursing-home day care; and for medical, nursing, and home help services in home care.

Administration follows the model of acute-care health insurance. The same sickness funds are the fiscal intermediaries for AWBZ. They pay the nonprofit and municipal owners of nursing homes, and they pay the Cross Associations who deliver home care. Daily rates are set by the same rate-setting commission that screens the prospective budgets of acute-care and extended-care hospitals. As in the hospital sector, the rates cover both operating and capital costs.

From the perspective of patients, AWBZ has been a great success; nursing homes are very comfortable, varied in programs, and well-staffed. But AWBZ is a principal source of the great increase in Dutch health care costs that have been an urgent public policy problem throughout the 1970's and 1980's. Dutch hospitals and nursing homes have been allowed to self-finance their construction and equipment--i.e., borrow and amortize debt through operating revenue--with the result of overly lavish facilities and very high permanent costs. Costs in both acute and long-term care have finally been contained--but at a high level --during the 1980's.

AWBZ has been able to avoid tensions with for-profit providers, because they do not exist in Holland.

I have not yet studied the financing and administration of home care under AWBZ, so I cannot judge achievements and problems. Home care has always been a Dutch forte, and doubtless the Cross Associations have prospered under AWBZ.

Public services have always existed for the indigent elderly in many countries. They have been improved and become available more widely, so they cease to be merely the "safety net" for those lacking help from family and church. Scandinavia has been the most generous provider, as part of its full menu of social services to all classes and age groups. Services are delivered by employees of municipal agencies and are paid by the budgets of local governments, often with the help of intergovernmental revenue transfers from national and provincial governments.

Such programs for the elderly and other groups are expanded enthusiastically in richer countries during economic growth. They are fixed at those levels when economic recession occurs. Considerable anxiety then follows--as in Sweden and Denmark--since high income taxes may dampen incentives for workers and entrepreneurs, high business taxes may price goods out of export markets. But the programs are not cut, aside from limited increases in beneficiary cost-sharing.

Public grants are used in some countries in lieu of long-term care insurance and in lieu of long-term care insurance and in lieu of direct provision by government. Private providers are already in place and government enacts grants to help users pay their bills. Canada pays nonprofit and municipal acute-care and extended care hospitals in this fashion, and its long-term care programs follow the pattern. The unusual aspect is that most of the nursing homes and home-care agencies are proprietary. Therefore, as in American Medicaid, public funds pay for-profit providers, for care to vulnerable people. I have not studied long-term care in Canada, so I cannot judge whether Canadian provinces encounter the same problems as American Medicaid.

Private providers of long-term care have complicated financial accounts, because their revenue comes from several sources. For example, the Cross Associations of Holland support their varied programs for old and young from grants from local governments, insurance payments from AWBZ, premiums from their own subscribers, and out-of-pocket payments by users. Canadian nursing homes receive Ministry payments for patients admitted according to the official program and private payments by other patients. In contrast, paying the acute-care hospital outside the United States is much simpler.

Cost-sharing. Institutional long-term care delivers housing, meals, and personal services that the older person would normally purchase at home from income. Any person going to a nursing home or receiving home services privately must pay in full. Under insurance or a public program, if the taxpayer paid in full, the patient and his/her heirs would enjoy a large financial windfall.

The universal spread of social security pensions in Europe and Canada--usually more generous than those in the United States--have given substantial private purchasing power to the elderly. Therefore, every country expects the patient to pay a substantial part of the daily costs of extended-care hospitals and of nursing homes. The amount covers housing and food. Usually the amount is fixed annually by public policy, instead of calibrated to each individual's ability to pay. If the patient is too poor--because of a low or no pension--the patient's share is waived or subsidized by a government welfare fund. Since the pension is earmarked for health providers, the national government's pension institute participates in the decisions about rate-setting and cost-sharing.

Cost sharing is also expected in home care services, either a share of an all-inclusive daily rate, a percentage of itemized charges, or copayments.

When no public grants to private nursing homes exist, the supposedly private transaction with the patient still involves public money, viz., the patient's pension check. The nursing home may claim some or all of the check every week. In Britain, one hears complaints about exploitation of patients by proprietary nursing homes, as in American Medicaid. Laws may be passed to reserve some of the check for the patient, but enforcement is difficult.

Health insurance was constructed for workers who paid premiums from wages and from employers' payrolls. When the elderly were added to NHI and multiplied in numbers, Europe entered its cost containment crisis. The elderly paid little or nothing, they brought no employer contributions, and they were the heaviest users. Taxes were raised on the workers and employers, starting during the 1960's, making NHI massively redistributive between the generations. But this was only a brief stopgap. The French, Dutch, and some other national governments during the 1970's rescued the sickness funds with annual subsidies from general revenue. (Once this option was proposed for the Medicare HI Trust Fund, and it always has been used for the underfunded Medicare SMI Trust Fund.) Strains on the national government budgets thus were added to strains on the structure of social security taxes.

Premiums from all the elderly have either been introduced for the first time or have been increased during the late 1970's and the 1980's. It is presumed that pensions enable them to pay premiums. But the costs of their acute care far exceeds their premiums. The elderly pay no premiums for Dutch AWBZ.

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LONG-TERM CARE IN CANADA: LESSONS FOR THE UNITED STATES

Testimony Submitted to the
House Select Committee on Aging

"Continuing Care: International Prototypes for America's Aged"

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LONG-TERM CARE IN CANADA: LESSONS FOR THE UNITED STATES

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Canada's experience with expanding its programs of universal health insurance to include long-term care offers valuable insights for the United States. Most Canadian provinces offer universal long-term care benefits that include health, personal care, and social services for functionally impaired persons. Such services are offered both in residential settings like nursing homes and the community. Eligibility is based on functional impairment without regard to the individual's income; co-payments, if levied, are designed to leave even the poorest pensioner with a modest disposable income.

In the fall of 1981, with funding from the Henry J. Kaiser Family Foundation, we undertook a two-year study of long-term care in three provinces--Ontario, Manitoba, and British Columbia. We sought to describe trends in the use and costs of long-term care under the universal benefits. All three provinces covered institutional and community long-term care; the latter two had introduced active programs of community-based case management. An examination of the systemwide effects of such operational programs complements findings from the numerous demonstration projects conducted in the United States. Our findings are presented more completely in a professional paper (Kane, RA & Kane, 1985) and a book (Kane, RL & Kane, 1985).

THE PROVINCIAL PROGRAMS

Certain characteristics are common to the long-term care programs in all three provinces. Nursing home care is insured with no means or asset test. All adult provincial residents are eligible. Functional impairment is the basis for eligibility. Clients pay a modest fixed room charge, designed to leave even those dependent solely on government pensions with a small discretionary income. Typically, proprietary facilities are paid on a per diem basis annually negotiated for the whole province, whereas nonprofit facilities are paid on the basis of prospectively negotiated global budgets. Home care (i.e., home nursing and homemaking) is purchased from nonprofit and for profit agencies or, at times, provided directly by public health or social service department employees.

Table 1 contrasts several characteristics of 1982 nursing home care in the three provinces with the overall scene in the United States. The bed ratio per 1,000 elderly in the United States is about midway between the range of the Canadian provinces, although the American variation among states is much greater. The 1982 public expenditures per nursing home bed varied by almost 50 percent, averaging about $12,000 (Canadian) (or $9,600 U.S.) compared to combined state and federal expenditures of about $10,000. Remaining cost in the Canadian provinces is largely financed by user fees paid directly by the consumer. (Each province establishes a fixed per diem as a "ward rate" at an amount keyed to the minimum pension. Additional charges for private rooms and specified amenities are permitted but strictly controlled.) The total costs per bed were higher in the United States than in any of the three provinces. Manitoba's rate of $19,249 per bed translates to $15,400 (U.S.). There is great variation in proportion of nursing home beds operated by proprietary firms. Ontario comes closest to the United States' pattern of proprietary predominance.

Table 2 summarizes the principal features of the three provincial long-term care programs. Each is described in some detail below to illustrate the variations possible around the general theme of universal coverage for long-term care.

Ontario

In 1972, Ontario began its extended care benefit, which covered "standard ward care" (i.e., 4 beds to a room) in a nursing home. Residents pay a fixed daily amount keyed to minimum government pensions. As of 1984, the user charge was $15.68 per day; this left residents who were entirely dependent on minimum government income maintenance programs with $96 per month for personal expenditures (an amount at least three times larger than the most generous state Medicaid program allows). Additional charges for semi-private and private accommodation (when not medically required) and other amenities are strictly controlled and generally affordable. A physician's evaluation determines eligibility, but it is then up to the client to find a nursing home.

The extended care benefit is used in two distinct types of facilities: nursing homes and homes for the aged. Nursing homes, which are 95 percent proprietary, are paid at a flat per diem rate negotiated annually between the Ontario Nursing Home Association and the provincial government. In 1984, that standard rate was $42.35 per day, with the government paying the $26.67 that remained after the user contribution. At that time, the province had 332 nursing homes and about 29,000 beds for its population of 8 million. When the government requires more beds in a geographic area, it undertakes a competitive bidding process. The award of the right to build more beds is made not on the basis of price (because the per diem is fixed) but on the relative quality promised in the proposals.

Homes for the aged are social welfare programs that predated the extended care benefit. They were established by municipalities or nonprofit organizations to provide residential care to seniors who could not or preferred not to live in the community. Residents pay according to their means, and the deficits of the homes are met by the sponsoring organization or municipality and the province. When the extended care benefit was introduced, qualified residents of homes for the aged were able to take up the benefit without relocating to a nursing home. There are now approximately 13,000 persons in extended care beds in homes for the aged (compared to 14,000 in the residential bed category). Such clients pay the customary user charge, but the home is paid its actual expenses, because the government picks up its deficit. Under that system, not surprisingly, extended care costs more per capita in homes for the aged than in nursing homes.

Ontario also maintains a category of chronic hospital, which in 1982 had about 11,500 beds. Those beds are paid for as part of the hospital's global budget from the province. Chronic hospitals may be freestanding but more usually are sections of general hospitals. As part of the hospital insurance system, the chronic hospital is free to the user. However, after the 60th day, all residents in chronic hospitals (and indeed all residents in acute hospitals waiting for a lower level of care) are assessed the $15.68 daily residential charge.

Since 1968, Ontario has had a medically-oriented acute home care program as part of its health insurance benefit. It includes nursing and therapeutic services and a maximum of 80 hours of homemaking per admission. Beginning in 1975, a Chronic Home Care program was piloted--it permitted 80 hours of homemaking in the first month and 40 hours in each subsequent month per admission, assuming that at least three professional visits a month were required. By 1984, chronic home care was available in each of 38 health districts, and the province was considering a homemaking service benefit for persons not requiring professional home care.

Home care is free to the user. Its amount is determined by home care case managers located in each health district. The Ministry of Health rchases nursing from voluntary agencies at rates negotiated province-de. The Ministry of Health purchases homemaking services either from nprofit agencies (the Red Cross is a major vendor) or proprietary encies at rates negotiated by social service authorities in each unty. Although the home care case manager has a sharply limited role, e is a major force for rationalizing home-based service. Entry to stitutional services is more unruly. In some districts, agencies lled Placement Coordination Services have been established by luntary agreement among the hospitals and long-term care facilities in e region. In those cases, the placement coordinator completes an sessment of all extended care applicants and manages a centralized iting list.

nitoba

nitoba is a vast province with only about a million people, half of om are in Winnipeg. Its long-term care program differs from Ontario's several respects: the physician's role in determining eligibility is ch less, its home care services are better developed, and the system s more controls. Only about a quarter of its nursing homes--called rsonal care homes--are proprietary.

nitoba recognizes 4 levels of nursing home care, ranging from Level 1 here residents are assumed to require no more than 30 minutes of daily rsing attention, most of it capable of being given by nursing sistants) to Levels 3 and 4 (where residents are assumed to need at ast 3.5 hours of nursing care per day, 20 percent of which requires a egistered nurse). Level 4 is analogous to Ontario's chronic hospitals n clientele, and is usually delivered in extended care units of general ospitals. Manitoba has a higher ratio of nursing home beds per elderly opulation than the other provinces studied, largely due to an accrued xcess of minimal care Level 1 beds clustered in facilities not suitable o treat more severely impaired clients. As in Ontario, the resident ays a fixed per diem keyed to the pension system. (In 1984 it was 13.) Proprietary homes are paid on a daily rate for each level of care egotiated with the government, and nonprofit homes are paid according o global budgets negotiated prospectively.

ince 1975, community care and case management have been provided by ontinuing Care Programs housed in each local health and social services epartment. Nurse/social worker teams serve as continuing care oordinators, who assess eligibility for all long-term care services ncluding nursing home care, home care and day care. Homemaking is rovided directly by public employees up to the hours authorized by the are coordinators. Nursing and other therapeutic services are usually rovided directly too, but, especially in Winnipeg, may be purchased rom nonprofit agencies. All home care is free, with no co-payments.

o person may enter a nursing home without the case being reviewed by an nterdisciplinary panel. The home care coordinators are responsible for ssessing applicants for nursing homes, organizing the information for he panel hearing, and managing the waiting list for those accepted for acilities. At the panel, medical information from the applicant's own hysician and social information are reviewed, providing a failsafe against admitting a person to a facility for a functional impairment instead of trying to remedy the problem. Because home care coordinators also manage admission to facilities, there is a link between the two benefit programs and the possibility for tradeoffs in their use. Home care expenditures per client are usually constrained to those for nursing homes at the same level--exceptions are made for short-term terminal care or in instances when no nursing home bed is available. Applicants are encouraged to make their own first and second choice of facility. If forced to enter a different facility to free up a hospital bed, they are waitlisted for the facility of their choice.

British Columbia

British Columbia's program is modeled after Manitoba's. Both insured facility care and insured homemaker care took effect in January 1978 after a well-advertised public information campaign. This provided a sharp test of the new system's ability to meet the initial demand. All adult residents of British Columbia are eligible for insured nursing home care, subject to modest user charges as in Ontario and Manitoba. Five levels of care are recognized: Personal Care, three levels of Intermediate Care, and Extended Care. The latter is generally given in extended care units of hospitals to persons unable to transfer independently from bed. Intermediate Care III is largely reserved for psychogeriatric care. During our study period, nonprofit facilities were paid according to negotiated global budgets and proprietary facilities were paid fixed per diems. In 1984, the province introduced a per diem rate approach for all facilities.

The province, which has about 2.8 million population, is divided into 22 districts for the administration of the long-term care benefit. In each district, case managers, who are usually nurses but may be social workers or physical therapists, assess the functional status of any applicants and determine their level of care. These case managers may authorize homemaker services up to maximum limits set for each level of care. For example, a person assessed at the personal care level is entitled to up to 40 hours of homemaking per month whereas a person assessed at the extended care level is entitled to up to 120 hours of homemaking per month. Exceptions to these limits are allowed in emergencies, as respite for family caregivers, or to persons waiting for space in a facility. The case manager may also authorize day care. If the applicant prefers a facility, the case manager puts him on the waiting list and home care may be provided in the interim. Homemaker service is purchased from forprofit and nonprofit agencies. Home nursing is provided directly by nurses employed in the public health departments where the case managers are also housed.

Case managers in British Columbia are expected to review each case every six months, after every intervening hospitalization, or as requested by the client or the care provider. Case managers continue to follow up with their assessments of level of care and their planning after a client enters a facility, a contrast with Manitoba's system. However, British Columbia has not introduced a paneling system analogous to Manitoba's.

GENERAL OBSERVATIONS

The more detailed study available elsewhere demonstrates that universal long-term-care entitlements are feasible and affordable. It is possible to deliver long-term care without bankrupting either the country or, equally important, without bankrupting families.

The Canadian experience with long-term care has demonstrated the feasibility of achieving several socially desirable goals. It shows that expanded services can be provided within a controllable budget. This observation should not be misinterpreted to say that new resources can be created from old at no cost. Money was infused into the Canadian long-term-care programs, but the expansion has been reasonably well controlled. Each of our three provinces developed a distinctive program of long-term care upon the foundation of its universal health insurance program. Whatever the provincial policies, universal long-term-care entitlements did not lead to runaway utilization. Each province developed mechanisms to control use. The more generous the benefits, the more necessary was effective case management to ensure accountable allocation of resources.

The Canadian long-term-care system allows for considerable exercise of consumer choice. With available options for home or institutional care and even variations in the ethnic composition of institutions, consumers are encouraged to express a preference and, within the limits of available resources, that preference is honored. The centralization of payment for long-term care provides an important element of control and makes planning possible. Standards can be established and supply regulated by authorizing payment.

Still, the Canadian approach has not solved all problems: The place of long-term care vis-a-vis social and health-care services is not clearly fixed. There is evidence of both redundancy and omission. In the health-care areas, for example, hospitals continue to operate the extended or chronic care units directly. Although every nursing home resident must have an attending physician, physicians in practice are too often not actively involved in planning for or delivering long-term care.

Control of the System

The elimination of multiple payment sources permits a great deal of control. Government monopsony facilitates more deliberate planning for long-term-care services. The system of global budgets, in principle, allows general allocation decisions across sectors to be made on a higher level of government while leaving to smaller units the opportunity to set priorities for the use of the supposedly fixed resources thus made available. Because decisions can be made about the amount of resources to be allocated to a program, there is a greater opportunity to control the level of expenditure. In practice, however, the government's control is far from absolute. Providers continue to exert substantial influence both on an individual level regarding planning for specific services, and on a larger collective level through lobbying efforts.

The three provinces studied vary in the extent to which services are provided directly or purchased. In some cases, the pattern seems to have resulted from historical accident--the presence of a strong organization already delivering a certain service; in others, it evolved by choice. In British Columbia, we encountered some strong sentiment in favor of purchasing services rather than providing them directly. The arguments favoring this approach addressed matters of administrative simplicity and control. Administrators felt they had more control with fewer headaches when they could contract for services and hold a third party accountable.

The strategy for controlling costs seems to revolve on two principal axes--controlling supply and controlling entry. In British Columbia and Manitoba, and to a much more limited extent in Ontario, an area of major control in long-term care is placed at the point of entry. Case management is used as a mechanism for controlling use and hence for controlling cost. Once a client enters the system, his or her utilization hinges primarily on available resources. Supply is controlled by limiting beds within institutions (both the numbers of new beds and the numbers of existing ones authorized for payment), and limiting dollars available to support community services. The role of case management then is to make the most effective use of the resources available.

Consumer Choice

The decision about the level of care needed was made independently of the decision about institutionalization, but case managers could be pressured to recommend a nursing home rather than home care. However, despite the perverse incentives inherent in the system, we were repeatedly reassured that most clients had a strong desire to remain at home as long as possible. This desire served as a deterrent to the financial benefits attached to institutional care.

Properly executed, case management should facilitate consumer choice, except when consumer preferences substantially vary from assessed needs. To permit a choice, there must be alternative modes of services. The greater the range of services and flexibility permitted, the greater the opportunity for choice. The two provinces with well-developed community services and case management provided both the means and the opportunity for choice.

In all three provinces, clients entering nursing homes had at least some opportunity for choice of facility. They were permitted to indicate preferences based on location, ethnicity, ambiance, or other factors. They were automatically placed on the waiting lists of the homes of their choice. Their acceptance of a less desirable, but available, place did not alter their waiting list position for their preferred home.

Conversely, the homes also had freedom of choice. They could accept or reject potential clients. Generally, homes paid on a cost basis were more malleable than those paid on a fixed per diem rate, where the problems of market skimming were akin to those in the United States. The case managers, or coordinators, often played a brokering role, negotiating a placement for difficult clients in exchange for a promise of some easier clients in the future. Again, when the case management system controlled access to nursing homes, the greatest leverage was possible.

Although we must not idealize consumer choice in the Canadian programs, they provide a sharp contrast with current United States policies under Medicare and Medicaid. Our Medicare policy provides an incentive to enter a nursing home from the hospital, the worst possible place from which to do shopping. The client has the worst of all worlds; the client is "placed" in an available bed from the hospital with almost no real choice of facility; the client has a disincentive to return home to choose a facility because of the Medicare three-day rule and the limited availability of home care; and if the client finds a facility he or she likes, there is no guarantee that the bed will be retained for the client if he or she is rehospitalized.

Relationship of Long-Term Care to Health and Social Services

In all three provinces, there was some fragmentation between health and social service responsibility for long-term care; the fragmentation was less in British Columbia because the unification of these responsibilities into a single provincial ministry and the integrated delivery system for many community health and social services at the local level. In all three provinces, the health components of the long-term-care programs were administered separately from acute health care. Such separation resulted in problems both in policy formulation and operation. If both acute and long-term care fall to a single administration at the higher levels of policymaking, planning can better incorporate shifts from one area to the other. However, unless it is possible to trace individual clients in both systems, it may be difficult to estimate the savings that would accrue from various shifts.

In practice, none of the provinces had an information system that operationally linked acute and long-term care even within the health department, let alone across the departments of health and social services.

Relationship Between Hospital and Long-Term Care

The hospital is the giant in the health-care-delivery system, with a commensurate gigantic appetite for resources. There is always a danger that the smaller long-term-care program will be reshaped to serve the ends of the hospital rather than to follow the program's own internal priorities. Hospitals in the three provinces had their own discharge-planning apparatus. Sometimes the long-term-care programs delegated to hospital personnel the initial assessment of the need for long-term care. Conversely, as in Manitoba, the long-term-care programs also locate staff in the hospital to do assessments. But even without formal delegation to hospital personnel, the long-term-care program is still heavily reliant on information provided by hospital staff. The incentives of such persons are, therefore, important.

The failure to link acute and long-term care can have deleterious consequences. Not only may patients be more aggressively moved from hospital to nursing home, but the reverse may also occur. In none of the provinces are there any incentives to encourage treatment of acute conditions in nursing homes. The general expectation is that, when the patient's care-needs exceed the capacity (or the willingness) of the nursing home, the patient will be transferred to the hospital. By contrast, the extended care units operated as part of a hospital are more likely to treat patients for a variety of problems incidental to their chronic debilities. Because nursing-home beds are usually held for long periods for patients who might potentially return, no exchange of patients occurs to release acute hospital patients awaiting nursing-home admission.

Relationship of Physician Care and Long-Term Care

Perhaps the weakest interface between the acute and long-term-care systems relates to the role of the physician. Dominant in acute care, the physician must play an important but not necessarily central role in long-term care. The challenge is how to assure that the client receives appropriate medical attention without medicalizing all the care offered. In the main, long-term-care clients are treated like other elderly persons in the society. They receive primary and specialist medical care as their conditions warrant. Institutionalized clients may receive their primary care from their original physician, or a single physician may care for all residents as a matter of convenience. In Manitoba and British Columbia facilities and in Ontario private nursing homes, residents usually retained their own physicians. In Ontario Homes for the Aged, the physician usually was employed by the facility. Patterns seem to differ according to type of community. In rural areas, the physicians doing community practice are very likely to attend in the facilities.

Manitoba has developed its paneling procedure as a mechanism to improve medical input while overseeing case managers' decisions. The panel, which reviews all cases proposed for nursing-home care, includes a geriatrician, and cases can be screened to identify those needing more intensive medical evaluation. The long-term-care programs can contract with geriatric assessment programs to conduct the more extensive evaluations when indicated. Community physicians are invited to participate in the paneling sessions when their patients are discussed, but few do so. They also receive feedback about panel recommendations when they alter the management plans. The very existence of a paneling system provides an inducement to careful initial evaluations. Of course, once the system is in place, one needs to guard against its becoming perfunctory.

Quality Assurance

Canada resembles Europe more than the United States in its approach to quality assurance. One encounters a much greater belief in the integrity of the system to perform properly. There are fewer regulations and more collegial relationships between the regulated and the regulators than are found in the United States. Formal studies on quality of care are not as prevalent. Data on performance are not readily available to the public.

The province in which we encountered the greatest dissatisfaction with quality was Ontario, and most of it was directed toward the proprietary nursing-home industry. The system of nursing-home inspections has been challenged as too weak. Prior notification allows the home to prepare for the inspection. The results of such inspections are not made public, thus preventing better consumer choice among homes. The voluntary system of accreditation operated by the Canadian Council on Hospital Accreditation is also challenged as self-serving and provider-dominated. Because accreditation is associated with less intense subsequent inspection, the overall effect may be to diminish quality assurance.

Auspices

The Canadian health care system reflects a general preference for nonprofit care, either public or private nonprofit. The proprietary institution has not gained as established a position in Canada as it has in the United States. But proprietary operations are not unknown in Canada, especially in long-term care. In both countries, data directly measuring the differences in care provided in institutions or programs operated under proprietary and nonprofit auspices are difficult to obtain. In at least two provinces studied, British Columbia and Ontario, policies about the desirable extent of proprietary long-term care were being reevaluated.

In British Columbia, the initiation of the long-term-care program was associated with a deliberate policy to encourage the growth of nonprofit nursing homes. This decision was the product of belief in inherently better quality, but the implementation was catalyzed by financing opportunities for low-interest Canadian government loans to nonprofit organizations.

As in Manitoba, the institutional payment scheme in British Columbia addressed nonprofit and proprietary homes differently. The former were paid on a prospective global budget similar to that used for hospitals; levels of care were used as crude yardsticks but, in general, costs of care were met. There was thus no incentive to economize. By contrast, proprietary homes were paid a fixed rate by level of care. They were expected to provide necessary care within this negotiated rate. Pressures for efficient management, and dangers of skimping on care, were thus more intense. Anticipated complaints about underpricing and unfair competition were heard.

After four years of experience and several changes of government, British Columbia officials have begun to reevaluate the situation. They express open concern about the lack of strong administration, evidenced by many of the nonprofit organizations sponsoring nursing homes and a belief that these organizations have neither the motivation nor the technical ability to reduce expenditures. Although there remains an intrinsic belief that nonprofit groups provide a more attractive environment for long-term care, there are few hard measures of qualitative difference. More and more, we heard long-term-care officials speak positively about the management skills of the proprietary firms and the desirability of linking them more effectively to nonprofit operations, perhaps by means of management contracts.

The Ontario situation is quite different. Nursing-home care is very heavily a proprietary industry, but that segment of it operated through Homes for the Aged belongs either to municipalities or nonprofit organizations. The latter are financed by the Ministry of Community and Social Services through a complex system that combines a per diem payment for nursing-home care with global budgeting for residential care. At least it is more closely tied to costs rather than the fixed per diem rate approach used by the Ministry of Health to pay for nursing-home care.

The most compelling argument for nonprofit sponsorship is the potential for public accountability. Board members of nonprofit organizations derive gratification from the esteem of their peers in the community. That respect is directly related to the reputation of the institution. Proprietary boards pursue different agendas related to profits and are accountable to a different constituency. However, the pride that motivates nonprofit agencies may also produce conflict with government agendas. The belief in what they are doing may render nonprofit organizations less malleable. By contrast, proprietary groups, viewing the government as the influential shaper of the marketplace, will make great efforts to accommodate to proposed changes as a means of increasing their market share. Governments may view the malleability of the proprietary sector as an unmitigated advantage, but checks and balances for an excessively parsimonious government may come best from nonprofit providers.

LESSONS FOR THE UNITED STATES

Going Beyond Demonstrations

We looked at the Canadian experience as a means of complementing the results of circumscribed demonstration projects at home. It appears that the results are consistent, or at least compatible. Providing community-based long-term care does not inevitably reduce institutional care utilization. The use of nursing homes is essentially a product of their availability. Hence the most effective means of controlling nursing-home use is by rationing supply.

Despite the centrality of supply in dictating nursing-home use, community care can still affect institutional utilization in the long run. The additive vs. substitutive dichotomy is too simplistic a formulation. Indeed, social research results can easily be misinterpreted, given a failure to recognize the dynamic nature of the environment. In contrast to physical science, causal relationships are not fixed; rather, the major players adjust their behavior to adapt to changed circumstances. Although one cannot realistically expect that the addition of one type of service will automatically displace another, the availability of the new program provides a climate for more purposeful action toward the desired end. The very presence of community care creates a social and political climate conducive to pursing a deliberate policy of controlling institutional supply. Community care in such an instance is not causal but enabling. It facilitates carrying out a desired policy.

This lesson is important for those planning long-term care in the United States. Unless those who operate the system have control, the system is unlikely to work as promised. We cannot count on effects resulting simply from displacement of one care modality by another. Thus, centralized funding again emerges as a critical component needed to shape the long-term-care program.

Long-Term Care as a Social Program

Long-term care is, by definition, a hybrid between health and social services. This is inevitable because long-term care is an undifferentiated mixture of what is needed to improve functioning or to compensate for functional impairments. In the United States, current long-term-care arrangements are criticized both because they are too medically oriented (i.e., the benefits are nested in expensive and sometimes inhumane medical programs while obvious social needs remain unmet) and also because they are insufficiently medically oriented. Timely and appropriate medical diagnosis and treatment are often lacking, with social services and residential placements used to compensate for functional disabilities without earlier medical efforts to improve that functioning. Although the benefits for long-term care were more generous and accessible in the provinces studied than in the United States, these polar problems of too much or too little medical or social involvement remained.

A socially based system of long-term care has much to commend it. Long-term care as a health program leads to second-class health care. By contrast, provision of long-term care under social auspices does not imply any loss of benefits for medical care or hospital care under universal health entitlements. Long-term-care clients would continue to receive health care on the basis of their medical needs, but the overall coordination of the services related to their functional dependency would rest elsewhere. The long-term-care client would have an additional set of advocates to urge more intensive medical attention to appropriate problem areas. Organized coordinating mechanisms, like Manitoba's paneling process, may further facilitate coordination between health and social care. It is important to distinguish between general management and medical care. The program would be directed at maximizing functioning by combining medical treatment with environmental manipulation. In the hands of case managers without prejudices toward one mode over another, it would permit creative solutions.

Social operation is not inconsistent with health sponsorship. Long-term-care funds are most likely to be successfully obtained from a reallocation of health dollars. The critical element is to make the allocation decision at a policy level rather than leave it to practitioners who face constant demands for service. The several provinces illustrate mechanisms by which this reallocation can be accomplished by program budgeting, but such budgeting requires an ability to set bounds to spending. The open-ended health-budgeting approach is not consistent with allocation strategies.

Need for Decentralization

Another major lesson from Canada concerns program scale. Although Canada is geographically larger than the United States, its total population is analogous to that of California. Some Canadian provinces have populations more akin to many United States counties. In Canada, long-term care is largely a provincial issue and even then it is administered at more local levels. As is the case in Europe, although policies can be made centrally, the program's operation requires active local control (Kane and Kane, 1976). Extrapolating to the United States, we see the need for programs built around manageable geopolitical units generally smaller than a state. The federal role would be heavily weighted toward financing--probably in some sharing arrangement with the states--and the assurance of minimal program guidelines and standards that provide at least a floor of equity for the program. This pattern has been established in the United States with other programs such as Medicaid.

Community Care

The Canadian experience offers further solace to advocates of community care. Providing such a benefit with broad coverage of homemaker services as well as nursing did not lead to runaway utilization. The use of such services is controllable by relatively simple case management, and control becomes easier as the shape of the program and concomitant public expectations become established.

The heart of the community care programs is homemaking services. A small number of people needed hands-on nursing, but the overwhelming majority needed only assistance with basic tasks. Nursing and other therapist needs, if present, are more likely to be episodic. In all three provinces, homemaking programs were operated as social agencies rather than health programs and maintained separately from the home-nursing services. In many instances, the amount of care needed weekly was quite modest, sometimes only a few hours. These small aliquots of service, often provided to supplement informal care, were viewed as critical to an individual's remaining at home. Although scientifically sound data to support these contentions are lacking, the strength of conviction of both providers and recipients is impressive. At the very least, such observations raise an important note of caution for those who urge more active restriction of services toward clients who have great gaps between service needs and extant resources.

Proprietary vs. Nonprofit

The controversy around the role of proprietary organizations in long-term care was not resolved by our look at Canada. Each province had a mixed portfolio of proprietary and nonprofit providers, although the proportions varied. Despite the concerns about the excess costs of nonprofit care, there is also an appreciation that it represents a different form of care. On the basis of national character, one would expect Canada to be more inclined toward nonprofit sponsorship than is the United States. Hospital care there is certainly much less proprietary than in the United States, but medical care remains predominantly in the private practice mode.

The extrapolation from our experience favors a mixed long-term-care economy that encourages productive competition between proprietary and nonprofit agencies. But the competition requires that both types of agencies be paid on the same basis. This prerequisite threatens to place the nonprofit programs at substantial risk, especially when there is some question about whether the two sponsors provide the same product to the same groups. To offset this danger, the government may want to assure the balance by setting minimum proportions of representation by nonprofits or considering some other form of subsidy that would not encourage inefficient management.

Role of Competition

America's entrepreneurial ethic has led to a strong faith in competition and the free marketplace as a means of assuring quality and reducing cost. This confidence may well be misdirected in the case of long-term care. Competition in medical and social services is more likely to produce duplication and gaps in service as various providers compete for the most lucrative markets and leave others uncovered. With a product as unspecific as long-term care, it is particularly unrealistic to expect the consumers to fend for themselves. When decisions are made in times of crisis, the likelihood of careful shopping is even more remote.

The United States lacks the guidance system to effectively direct competition in long-term care. The critical missing link in using competition productively in the United States is organizations that can assume both authority and responsibility for defined populations. These populations are best defined in terms of geopolitical areas to assure coverage and to avoid selection bias. Within this framework, various competitive strategies can be employed. Some will feature competition among different providers of the same service. Others will foster competition among various modalities of care to serve the same problems or clients.

Case Management

As long as we spend public dollars we will need some mechanism to control those expenditures and exercise responsibility for the most effective use of available resources. Two of the provinces studied developed extensive case management programs, and the third is moving to do so.

Case management is a popular concept in the United States today. It is important to distinguish, however, between a case management program for a universal public benefit as opposed to a residual means-tested benefit like Medicaid. If case managers must keep "hands off" until people have exhausted their resources in the private market, the impact of case management on the overall system is blunted. It becomes too little too late.

In advocating case management, we are not necessarily recommending a complex system. Inevitably, case managers will use professional judgment in their planning process. Because of the concern in the United States over the potential for litigation, there has been a tendency to rely on complex forms and elaborate decision models; completing the form is more arduous than working on the decision. What is much more desirable is a format that emphasizes common language and definitions but avoids pseudoscientific decision algorithms. Case management, as it evolved in Canada, is inevitably an inexact science that must rely on common sense, good will, and a responsive stance on the part of the case manager.

CONCLUSION

Our Canadian neighbors have shown that it is indeed possible to convert a long-term care system from a spend-down "welfare" basis to a universal benefit and to make the necessary adjustments of relationships among governmental units and care providers. This demonstration of the art-of-the-possible points the way to beginning the changes necessary in the United States.

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Table 1

COMPARATIVE DATA ON NURSING HOMES FOR THREE CANADIAN PROVINCES AND THE UNITED STATES, 1982

	Ontario*	Manitoba	British Columbia	United States
Nursing home beds/1,000 75+	113	114	168	141
Annual public $/NH bed	10,957	14,929	12,689	10,000
Total annual $/NH bed	15,277	19,249	16,829	18,200
% Nursing beds proprietary	69	29	37	76

*Includes extended care beds in old age homes.

NOTE: Canadian data are expressed in Canadian dollars and United States data in U.S. dollars. In 1982 the Canadian dollar equalled approximately $0.80 U.S.

Table 2

LONG-TERM PROGRAM DESCRIPTORS FOR THREE PROVINCES

	Ontario	British Columbia	Manitoba
Nursing Home Insurance started	1972	1978	1973
Home Care Insurance started	1972-for acute; chronic piloted in 1975 and fully operational in 1984	1978	1976
Institutional providers	Forprofit nursing homes; nonprofit homes for aged	Forprofit and nonprofit nursing homes	Largely nonprofit nursing homes
Access to Nursing Home Benefit	Physician triggers	Case manager assesses	Case manager assesses + panel hearing
Levels of Nursing Home Care	1*	5	4
Home Nursing provision	Purchased from agencies	Delivered by salaried nurse PHNs	Purchased in Winnepeg, delivered by PHNs elsewhere
Homemaking provision	Purchased from forprofit and nonprofit agencies	Purchased from forprofit and nonprofit agencies	Delivered by salaried employees
Access to Home Care	Home care coordinator assessment	Case manager assesses	Case manager assesses
Homemaker limits	80 hrs in first month and 40 hrs thereafter; must have 3 professional visits per month	Maximums per level of care --40 hrs per month for Level 1 and 120 per month for level 5	Must not exceed cost of nursing home care

*Ontario has a residential level of institutional care in homes for the aged that is a means-tested rather than a universal benefit.

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July 29, 1985

The Honorable Edward R. Roybal
Chairman
Select Committee on Aging
712 House Annex One
Washington, D.C. 20515

Dear Mr. Chairman:

The health care systems of Canada and Great Britain were discussed at the July 15, 1985 Committee hearing on "Continuing Care: International Prototypes for America's Aged," which I attended. I wish to submit the enclosed two articles which review the Canadian and British systems for inclusion in the official hearing record.

Thank you for your attention to this matter.

Sincerely yours,

Mark Siljander

MARK D. SILJANDER
Member of Congress

MDS:jv

Enclosures

[From the New York Times, Feb. 15, 1983]

HEALTH CARE IN CANADA: POPULAR SYSTEM NOW ROCKED BY CRITICISM

(By Douglas Martin)

When Tommy Douglas was a boy, a Winnipeg doctor told him that he was suffering from a bone disease called osteomyelitis and that his leg would have to be cut off. Only because a brilliant young orthopedic surgeon decided to use the young charity patient for a teaching demonstration was he lucky enough to avoid the amputation. "Had I been a rich man's son," Mr. Douglas says, "the services of the finest surgeons would have been available. As an iron molder's boy, I almost had my leg amputated before chance intervened and a specialist cured me without thought of a fee." Mr. Douglas grew up to become the Premier of Saskatchewan, head of one of the first socialist governments in North America. In 1962, his party established a comprehensive medical insurance system, providing, in his words, "complete medical care without a price tag." By 1971, such a system, administered by individual provinces and financed partly by the Federal Government, had been extended to cover every Canadian.

But now this comprehensive medical insurance system—which provides health care at substantially lower cost than the American system and has been closely watched by United States policy makers as a possible model for imitation—is confronted by wrenching pressures. The Canadian medical system lies somewhere between the American entrepreneurial approach and British nationalization.

A growing number of critics say that Canadian medicine has become bloated and inefficient, and they assert that the Federal and provincial governments no longer have effective control. Doctors point to mounting evidence of inadequate financing, including year-long waits for operations, hospitals so overcrowded that beds and obsolete equipment jam hallways. Most visibly, the physicians, with an average income of about $52,000 a year, complain that they are not paid enough and have gone on strike in several provinces to demand higher fee scales. And patients are increasingly asked to pay amounts above the insured fee, a contradiction to the system's founding philosophy.

At issue, analysts say, is the whole public nature of the system and how much of a new or expanded role, if any, private enterprise should play. "We have a great chance of losing our health system the way we know it," said Ginette Rodger, executive director of the Canadian Nurses Association.

The Canadian health system is really nothing more than an insurance plan for all citizens. The Federal Government and each of the 10 provincial governments put up the money, which comes from income taxes, sales taxes and, in the case of three provinces, premiums. Doctors bill the province for medical services. The theory behind the system is that the healthy, not the sick, should pay for medicine.

DIFFERENCES FROM UNITED STATES

Canada's public monopolization of medical insurance, and the guarantee of medical care to all, are the chief differences from the United States, where Government-financed health programs are limited to veterans, the elderly and the poor. Most analysts agree that national health insurance has been a dead letter in Washington for nearly a decade. There have been new expressions of interest in recent months, however, because 10 million Americans have lost health coverage since 1981 as a result of losing their jobs.

The relevance of Canada's health system to Americans appears to be its success in providing what analysts and doctors generally agree is good care for less money. Canada spends roughly 8 percent of its gross national product for medical services, as against the United State's 10 percent. If the United States could reduce its proportion to 8 percent, the saving would be about $60 billion. Analysts say much of Canada's lower cost stems from the absence of a complex maze of private insurers who have to earn a profit to stay in business.

"Almost nobody thinks that for our 10 percent we're getting value for our money," said Theodore Marmor, a professor of political science at Yale who has extensively studied the Canadian health apparatus. "In Canada, some do, some don't."

A NATIONAL APPROACH

Health as a political issue is coming to a head in Canada with the recent introduction in the national legislature of a bill proposed by the Government of Prime Minister Pierre Elliott Trudeau. Called the Canada Health Act, it would consolidate most existing programs. More important, it would limit doctors' ability to charge more than the insurance rates. The proposal has met strong response:

"We're going to be in for a dog-eat-dog confrontation," said Dr. Marc Baltzan, president of the Canadian Medical Association.

But in pointing out that the system is now badly underfinanced, the medical association says lives are already being jeopardized. "And as people die on waiting lists, governments are going to catch the heat," says Dr. Baltzan. They point to South Saskatchewan Hospital in Regina where 45 patients considered "urgent" candidates for open-heart surgery faced six-month waits; to patients with chest pains who would normally be treated immediately but who have been turned away from Western Regional Medical Centre in Yarmouth, Nova Scotia, because the halls are already crowded with patients on stretchers, and to Moncton Hospital in New Brunswick, where 30 beds are kept empty to save costs, despite a surgical waiting list of 1,400 patients.

DOCTORS FEEL UNDERPAID

The doctors' position is that such failings indicate governments' unwillingness to pay enough for hospital maintenance, expansion and improvements, not to mention their fees. More and more doctors, particularly specialists who feel they are not being adequately reimbursed, are charging patients directly for amounts in excess of those set by provinces.

Strikes have been another response. Over the last two years, physicians have struck in British Columbia, Alberta, Newfoundland, Ontario, Quebec and Manitoba. In almost all, the settlement was more generous than the government's original offer.

"Certainly we have a cheap system," Dr. Baltzan said. "The question is can you afford to run a system at that level for ever and ever."

Opponents counter that the doctors' real concern is their own incomes. As the number of physicians increased, the number of Canadians served by each declined, to 535 in 1981 from 808 in 1962, and the trend appears to be continuing. The dwindling ratio of patients to doctors makes it hard to increasing income by treating more patients, giving the doctors a powerful impetus for charging more per patient.

THREAT TO SYSTEM SEEN

The principal complaint against the extra charges, which so far make up less than 5 percent of total billings, is that they will gradually erode the public nature of health financing, a criticism also levied against the supplemental charges hospitals assess for private rooms and food. Some critics see a two-tier health system coming, one for the rich and one for the poor.

Despite the crowded hospitals, many in Canada believe the health system is financed adequately. They say the problem is that too many people are in hospitals who have no business there; that many medical problems could be treated at lower cost by nurses and other professionals rather than by doctors, who are the only individuals now reimbursed; that doctors spend too much money on fancy new equipment whose value has not yet been proven, and that doctors and hospitals have no intrinsic interest in controlling costs.

These assertions are often made by liberal economists. Robert G. Evans, one of Canada's most influential health economists, argues that a financial crisis is almost inevitable in a system under which physicians basically control how much billing will occur. Each province only controls the budgeting of overall hospital expenditures and the setting of a fee scale used to reimburse the independent doctors.

"We are now experiencing the consequences built into the way we designed our system," Mr. Evans said. "We presupposed the discretionary decision by physicians wouldn't break the bank."

Mr. Evans says the answer lies in more research to learn which proven medical methods are least costly. He argues that provinces should be told to find such cost-saving measures and then to require the medical profession to adopt them. "Where's the evidence that what an individual doctor determines is necessary is really necessary?" he asked.

DOCTORS PREFER INDEPENDENCE

Physicians counter that such proposals strike at the core of their professional integrity. The more independence they are granted, they say, the healthier their patients will be. As a result, they tend to reject the very idea of economic analysis as unsuited to their basic mission.

"Most people would be very reluctant to take the position that their being alive rather than dead constitutes a marginal benefit," Dr. Baltzan said.

The medical profession has proposed that the poor receive free medical care, while more prosperous patients pay more. That plan would answer the question of accessibility, but would not erase fears of the two-tiered medical system.

The question of health insurance reform is further complicated by the perennial issue of Federal-provincial conflicts. Although grateful for the Federal money that pays about half the cost of health care, the provinces jealously cling to their autonomy over health matters, particularly while budgets are strapped by the recession. The fact that the Liberal Party rules nationally but does not control a single provincial legislature makes matters even more acrimonious.

Despite all the criticism and pressures for change, a recent Gallup poll indicated that four-fifths of all Canadians are satisfied with their medical insurance plan. Doctors and hospitals, although they want more money for their services, generally do not want to scrap the system. One of its virtues, they say, is that they do not have the problem American doctor's problem of trying to collect from people who will not pay their bills.

"You'll never persuade the Canadian people to go back," to free-enterprise medicine, Mr. Douglas said. "They wouldn't stand for it."

[From the Wall Street Journal, Feb. 9, 1983]

Socialized Care—Frugal Medical Service Keeps Britons Healthy and Patiently Waiting—But It Has Given Up Dream Of All Remedies for All; Survival of the Loudest

RATIONING CAN BE IRRATIONAL

(By Barry Newman)

Bretby, England.—Bretby Hall is a Gothic-revival castle standing on a knoll in the quiet countryside of the English Midlands. It was built in 1777 by the Earl of Chesterfield. In 1927, with the Chesterfield line nearly extinct, Bretby Hall became a sanitarium. Ten years ago, it was turned into southern Derbyshire's center for the replacement of arthritic joints.

Every so often, a stone will topple from a parapet. The grand staircase inside is unreliable and roped off. It took seven years for the staff surgeons to get the money for a new operating theater. Bretby's proprietor, the British government's National Health Service, or NHS, stints on things like that. Four hundred operations are carried out here in a year on a budget below $2 million.

In the women's ward one rainy Tuesday, Beatrice Harrison is in bed, sipping tea, with a new plastic joint in her left knee. That knee acted up in 1978, when Mrs. Harrison was 64. "The pain was terrible," she says. "I could hardly walk." Her doctor decided she needed an operation and put her name on the health-service waiting list. Mrs. Harrison hobbled around with a cane for more than four years before she was offered a bed at Bretby.

WAITING FOR A HIP

Margaret Cornthwaite, 69, has the next bed. She had a knee done in 1979 after waiting three years, and has waited since then for a new hip. Her husband retired early to help her get around. "I've done perfectly well," Mrs. Cornthwaite says, tidying her dressing gown. "I'm willing to take my turn."

Even if these women had been willing and able to pay the health service for their operations, they couldn't have hoped for speedier attention. Pain doesn't always impress the NHS, the penurious granddaddy of socialized medicine in the West.

Angina is pain, the constricting pain of a hard-pressed heart. If you were British and had angina, the health service wouldn't give you a coronary bypass, an operation done 10 times more often in the United States than here. "It is an economic decision," says James Scott, the chief medical officer of the Trent region, which includes Derbyshire. "We treat to extend life, not to reduce pain."

In the United States, 250 people in every million can be treated for kidney failure if need be. Britain can treat perhaps 40 in a million, and younger people are given preference. So, if you were British and 55 years old and your kidneys failed, the health service probably wouldn't give you a transplant or a dialysis machine. If you were 75 or older, it definitely wouldn't. In other words, you would die.

A DREAM ALTERED

British socialized medicine, at the age of 35, has long given up the postwar socialist dream of providing "treatment of every kind to every citizen." The National Health Service today discriminates against the old. It favors rich regions over poor ones, the middle class over the working class. And when the better off with minor ills are sick of the system, they can choose private doctors; that's what Prime Minister Margaret Thatcher does for her varicose veins.

Strange to tell, however, the NHS has achieved one miraculous thing—the very thing, in fact, that might least be expected of a socialist dream: It has held the cost of health care to the ground.

Britain spends less on its sick than any other industrial nation, just 5.5% of its economic output. The United States spends nearly twice that. Yet, for all its penny-pinching, the NHS keeps the British in overall good health. Robert Maxwell, a leading medical analyst, mixed 17 measures of mortality and produced this singular result: Of 10 Western countries, the U.S. was second in spending but ninth in health; Britain was last in spending, fourth in health.

When the welfare state was ascendant, Britons liked to call their health service "the envy of the world." It may still be, though for new reasons. Every country in the West wants to cut the cost of tending the sick. West Germany wants pensioners to pay more toward insurance; France wants hospital patients to pay for their food. The Reagan administration talks of consumer choice, competition and "cost sharing" to dampen demand. But in Britain, cost cutting is relatively painless—for the government, that is, not the patients.

That is because government in Britain has a firmer grip on medical costs than many governments elsewhere. It pays 93% of the nation's medical bill, and it pays it directly through general taxation instead of through insurance. But the main reason for its hold on costs is that Whitehall doesn't just pay for health care; it delivers it. All it takes to slam down the financial brakes is the powerful foot of central government.

"It is a non-extravagant system," Mr. Maxwell says. "The NHS has been able to control costs in a way that is most unusual in the Western world."

Putting it bluntly, the NHS is a monster. It employs 51,000 doctors, 354,000 nurses, 101,000 cleaners, 19,326 secretaries, 1,344 plumbers. In a country of 55 million, a million people work for it. That makes the NHS the biggest boss in Britain, and in Europe as well.

It runs 2,625 hospitals with 474,000 beds, room for five million people a year. NHS ambulances drove 139 million miles in 1981. Its technicians repaired 80,000 artificial legs; its druggists filled 299 million prescriptions, and its dentists filled 30 million teeth. It all costs about $20 billion a year, and that all comes from one pocket in the chancellor of the exchequer's vest.

Getting money out of this monolith is no mean task, as health-service workers learned anew last year in eight months of fruitless job actions. NHS surgeons are salaried, not paid by the case, so they aren't tempted to operate when they don't have to. NHS rules forbid anyone to see a specialist before being screened by a general practitioner; that saves a bundle, too.

The visionaries who set up the NHS back in 1948 had one funny idea about costs: that they would go down as people got healthier. Things didn't work out quite that way. The healthier people got, the longer they lived. The longer they lived, the sicker they got. As the system became more efficient, it treated more patients. The more patients it treated, the more money it spent.

By the 1970s, the NHS budget was growing 4% a year. That was modest enough by world standards, but when the British economy went catatonic in the mid-1970s, Whitehall decided that it was too much. Health economists figure that the budget has to grow 1.3% a year for the service to stand still. In 1975, the Labor Party government imposed a flat limit of 1.5%. That lasted until 1982, when Mrs. Thatcher's Tories tightened the screw to just 0.5%.

The upshot is a kind of national triage. Government parts with the cash and lets every medical interest within the health service, from urologists to makers of surgical gloves, thrash out who gets how much. Decisions supposedly are made according to medical benefit: brain scans vs. pap tests, nursing homes vs. operating theaters. The trouble is that rationing isn't always rational. As money gets scarcer, it is increasingly being apportioned by a process of unnatural selection: survival of the loudest.

"We are desperately trying to improve facilities for acute patients while paying some regard to the needs of long-stay patients," Robert Alderton says. "Either we forgo new building to run existing services, or we sacrifice existing services to fund new building."

MOVING AWAY FROM US

Mr. Alderton is the frustrated administrator of the NHS district of southern Derbyshire. It is a working-class district, taking in the village of Bretby as well as the city of Derby, 13 miles to the north. Long before the NHS was born, Derbyshire and its neighbors in the industrial Midlands had less to spend on health than the influential, moneyed south of England. In 35 years, socialized medicine hasn't evened the score.

Internal NHS politics intervenes, just as it does when NHS planners try to divert money to the elderly and the mentally ill. The old-rich regions and the high-powered medical specialities are least likely to give up their advantages when times are hard. So for places like Derbyshire, as Mr. Alderton says, the goal of getting an equal share "is moving away from us all the time." Meanwhile, mortality rates among the working class remain strikingly higher than they are for the middle class. If anything, the gap is widening.

The one thing left shoring up NHS standards at this point may be the Dunkirk spirit. It certainly seems that way one night on Ward 4 of Derbyshire Royal Infirmary.

The infirmary, in central Derby, is an agglutination of outbuildings and temporary huts tacked on to a turreted architectural dowager opened in 1897. In the dim fluorescence of Ward 4, thirty patients are beginning to nod off when a nurse rushes along the row of beds to a phone in the corner office.

"We're terribly short-handed," she says after dialing a number. "I wonder if we could borrow someone to do the drinks? There isn't? Oh, fine. Not to worry. We'll battle on."

She hangs up and rushes out. A minute later, another nurse rushes to the phone, trailing a strip of crumpled graph paper. She makes a call. "Is that Frank? I've got this old portable EKG. It's playing up. Honestly, I can't get a reading at all. Can I? Oh thanks. Be right there." And she rushes out.

"It's like this in the NHS," says Cathy Cowley, the intern on duty. She is filling out the label of a blood sample in the ward office. "Private hospitals are different. Of course, I'm a bit anti-private myself. I don't like people being able to pay their way to the tops of queues. The NHS is fundamental to our way of life here. We're proud to keep it running."

Dr. Cowley's bleeper goes off, and she dials a phone number. "You want a chest X-ray? Righty ho. . . ."

A WORLD APART

Private hospitals are different indeed. East Midlands Nuffield Hospital is a few minutes' drive from the infirmary and a world apart: low-slung, landscaped and only a year old, it has the quiet, carpeted air of a small motel that just happens to have an operating theater at the end of the corridor.

Mary Palmer is in her private room at dinner time on another evening, watching color television and recovering from a quick operation for some town cartilage in her knee.

"It would take a year to get this done on the NHS," she says, putting down her knitting. "They look after you when they have time. Here, they do anything for you. It's super."

The British upper crust has long known the privileges of private care. But as the NHS budget gets tighter and its waiting lists get longer, people like Mary Palmer are discovering them, too; her husband installs storm windows for a living. There are 151 private surgical hospitals in Britain today and four million people privately insured. Right now, 785,000 people are on NHS waiting lists, every one a potential customer for private insurance.

IDEOLOGICAL SPARKS

Medical insurance of the British variety almost never covers the most expensive problems. Millionaires and foreigners aside, just about everyone in this country still joins the NHS queue in matters of life and death. But insurance does buy instant attention to a hernia, or varicose veins, or even an arthritic joint. It could ultimately buy more. Once again, money is becoming an arbiter of access to health care in Britain, and the ideological sparks are flying.

Mrs. Thatcher's government is for letting private medicine grow. It has allowed NHS specialists to take more private patients, eased restrictions on building private hospitals and handed tax breaks to some workers who buy private insurance. Last September, the government's official think tank actually put forth the option of financing the NHS through insurance and shunting a third of its cases to private medicine.

The idea surely delighted devotees of the free market who think a dose of competition would help reduce the NHS caseload while making it more sensitive to consumer demand. But the opposition Labor Party wasn't pleased. "The private sector," said its 1982 program, "can only profit as a parasite on the NHS." A Labor government, it promised, would put the kibosh on private practice and ban the building of private hospitals. It would solve the NHS money shortage by simply giving the NHS more money.

NAIVE PYROTECHNICS

Neither side gets much sympathy from British health economists like Alan Maynard of York University, who says that they both engage in "naive pyrotechnics." The free-market devotees are dreaming, Mr. Maynard and others argue. A truly free market doesn't exist in any real-world private health system, they say, because patients don't make economic decisions; doctors are the ones who determine demand, and insurance companies foot the bills. Socialized medicine, on the other hand, seems to Mr. Maynard more likely to ration care by "random choice" than by scientific choice.

Yet Mr. Maynard's sympathies ultimately lie with Britain's health service. He calls it "a unique and precious national asset," holding on to the ideal, at least, of equality—and doing so for very little money. "You don't have to be a collectivist ideologue," he says, "to appreciate the advantages of the NHS."

Margaret Thatcher is nobody's collectivist ideologue. Saving money is her goal, though. When it comes to health care, she for one is inclined to put free-market polemics aside for the sake of a low-cost system—at least until after the next election. In October, her Conservative Party soundly rejected the think tank's suggestion that the National Health Service be supplanted by private insurance. "The NHS," said Mrs. Thatcher, "is safe with us."

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July 16, 1985

The Honorable Representative Edward R. Roybal
Chairman, Select Committee on Aging
House of Representatives
Washington, D.C.

Dear Mr. Chairman,

The U.S. Committee on World Aging is pleased to offer some observations at this important hearing held in conjunction with the International Congress. This hearing is an example of a step that can lead to greater cooperation and collaboration among the nations concerned about aging issues.

The U.S. Committee on World Aging has accepted the mandate to continue to work for the implementation of recommendations from the Vienna Plan of Action. The U.S. Committee on World Aging is comprised of more than twenty organizations, all with a specific aging agenda and most with an aging constituency. We have divided among our member organizations some of the recommendations of the Plan to ensure that essential elements of the Plan will be given the attention they require.

We are pleased that this hearing focuses on long-term care because this is a dilemma that we face here in the States and around the world. This hearing takes note of the fact that we have much to learn from other countries which are grappling with this problem and seeking ways to provide quality long-term care. The very idea of the World Assembly was conceived as an opportunity for people of all ages to exchange information, to learn from one another, and to prepare for our changing, aging world.

The extent to which key recommendations of the Vienna Plan of Action are implemented depends upon thoughtful planning and purposeful activity among national governments and non-governmental organizations. It is reasonable to assume that the nation which took the lead in calling for the World Assembly would give high priority to seeing that the recommendations of that Assembly will be implemented--in the United States and throughout the world. It seems logical that the nation which provided substantial funds to make the Assembly truly representative would devote resources to ensure the implementation of recommendations vital to the aging populations of this nation and the world. It is reasonable to believe that the U.S. government, which provided for effective inter-agency preparation for the Assembly, would invest human and financial resources in appropriate follow-up activities.

Unfortunately, that is not the case.

Immediately after the Assembly concluded, the inter-agency committee was disbanded. It was, however, reconvened briefly to collect information for the U.S. response to the U.N.'s quadrennial reporting requirement. But even then, the United States was one of the few developed nations which failed to make its report in a timely manner. When the report was issued, it turned out to be a rehash of what the U.S. would have done had there been no Assembly. The report suggests to the careful reader that the United States has little interest in the World Assembly's recommendations and in international cooperation concerning aging issues.

We are very proud of the role the United States played within the World Assembly on Aging in working to develop an excellent report and sound recommendations. Thus the inadequacies of the U.S. report to the U.N. are embarrassing and discouraging. We know well, as this hearing demonstrates, that we have problems in common with both other developed and less-developed nations. These problems will have a far better chance of resolution through the exchange of information that takes place in an international forum.

It is because the U.S. Committee on World Aging believes there is an important role for NGOs in implementing the recommendations of the World Assembly on Aging, and because we see so little evidence of interest and support from the Administration, that we are grateful to you for prodding the Administration, Mr. Chairman, and for your continuing efforts to keep the U.S. aging program aware of our global opportunities and responsibilities.

In fact, the U.S. Committee on World Aging saw as its first task to bring pressure to bear on our government. Your leadership in developing a joint resolution calling for government-wide participation in implementing recommendations of the World Assembly on Aging, for the exchange of information and the promotion of aging research among the states, federal government, international organizations and among other nations is greatly appreciated by the U.S. Committee on World Aging. So far, the only encouraging result has been a step taken by the Agency for International Developement to inform its missions abroad about the importance of considering aging as a developmental issue for which proposals should be invited.

We are grateful to you, Mr. Chairman, for scheduling this hearing in New York City in conjunction with the International Congress.

The U.S. Committee on World Aging sees the problem of providing quality long-term care in a variety of settings for those unable to care for themselves as among the most important--if not the most important--challenge we face in this aging world. We strongly urge the U.S. Congress to take the steps necessary to guarantee to all those afflicted with infirmities requiring continuous care, both adequate health care and freedom from impoverishment due to health conditions.

In a nation with so many resources and with an historical commitment to care for those in greatest need--from the very days of our Declaration of Independence--it is a crime that we should be moving toward a health care system more concerned about saving dollars than preserving the dignity and quality of life for our suffering frail citizens. Our current strategy, still overwhelmingly tilted toward those in nursing homes and hospitals, is not only bad policy, but also very costly in human and financial terms.

There is little doubt that as many as five or more percent of the elderly population may require the shelter and services of an institution; certainly these people deserve the best possible care. But there is also little disagreement among those who have researched this issue, or simply tried to find appropriate, affordable, quality care for an aged parent, that our national policies leave people with few alternatives to institutionalization.

The U.S. Committee on World Aging is committed to the principle that for most frail persons, care should and can be provided within the family and within the community. While there are many barriers to the achievement of this goal, it is clear that those barriers must be overcome.

One need only compare the amount of health care dollars going to institutions with allocations to support care within the community in order to recognize the glaring lack of balance in our policies.

We have seen in Denmark and other countries that a system that does not segregate people according to the severity of their problems can work . We have seen in Japan and other countries that families can and will provide most of the care one needs if there is a tradition of families taking responsibility for their elders. We have seen in the Nordic countries that housekeepers and home health aides can provide the margin of care and attention one needs in order to remain in one's home despite infirmities.

We have, in short, a great deal to learn from other nations, both developed and developing these lessons are important for our own aging society. We can, with strong support from the U.S. government, of the U.S., develop lines of communication and encourage basic and applied research that will, in the long run, contribute to a higher level of life satisfaction especially among those most disadvantaged by poor health and inadequate income. Alternatively, without strong support from the U.S. government, progress toward this goal will falter.

In summary, while the U.S. Committee on World Aging is small, we are working to see that the sound recommendations forged in Vienna will be implemented. We will continue to work to find ways to translate valuable ideas into effective programs. We will be watching the Administration and the Congress to see if what we began back in the seventies will bear the fruit of informed public policy which, in turn, will increase the probability that older people will live lives as full of meaning and as free of suffering as is possible. We ask the U.S. government for the commitments necessary to reach this goal--a goal we share with other nations throughout the world.

We are the world--whether young or old--and the world requires, at the very minimum, our continuing concern, especially for those least able to fend for themselves and most dependent upon a caring society and world.

Sincerely,

James T. Sykes
Chairman, US Committe on World Aging
and Special Assistant to the Vice Chancellor

* CARE OF ELDERLY PEOPLE

** Alan Walker

The 'welfare state' is chiefly a welfare state for elderly people. A large proportion of its benefits and services go to them. They are the main client group of the DHSS, which has primary responsibility for implementing government social policy and planning. Elderly people rely overwhelmingly on the state for income, but this large-scale economic dependency is not matched by physical or social dependence on the state. Nevertheless, public health and personal social services make a crucial contribution to the quality of life and often the very survival of the minority of elderly people who use them and, in turn, just under half of public expenditure on these services goes to elderly people (CPRS/CSO, 1980, p.85). Considerations about the future of the 'welfare state' and social policy, therefore, are inevitably concerned with the well-being and status of elderly people. Changes in the demands for and availability of resources for the social services over the next 10 to 15 years are likely to have a profound impact on them.

The purpose of this paper is to set the scene for a discussion of the care of elderly people. What is the scale of need? What can be predicted with certainty about changes in the need and demand for services in the near future? What pressures will continue to influence the development of policy in this field? What principles should underpin policy? How, if at all, can the supply of resources for care be increased? How far can the preoccupations of policy-makers and the needs of elderly people and their families be reconciled in the development of social care policy? What priorities might be identified for policy and research? Because of shortage of space and time I have concentrated on the issue of care rather than treatment (see Abrams, 1978, p.78) although the distinction between the two is often blurred.

The Elderly Population and their Need for Care

Discussions about social policy with regard to elderly people usually start with an account of the recent and projected growth in their numbers and, while this one is no different, three cautions should be borne in mind.

It is now commonplace, in both official and independent documents, to describe Britain's ageing population in terms which often border on alarm. Descriptions

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such as 'the growing burden of dependency', 'social disaster', 'flood' and 'rising tide' create the impression that we are being swamped or taken over by growing hoards of frail elderly people (see, for example, Health Advisory Service, 1983). The fact that this is not the case, as I will go on to show, is difficult to establish in the face of such exaggerated language. This caricature of old age, which is at best restricted and at worst downright degrading, has its origins more in social and political institutions, particularly the labour market, than in demographic facts. We are encouraged to believe that the social problem of dependency exists just because the numbers in a particular age group are increasing, by the simple but mistaken translation of demographic projections into social realities. But dependency is a socially rather than a biologically constructed status. It is a product of a particular social division of labour and structure of inequality rather than a natural concomitant of the ageing process. So, the description of ageing by means of demographic statistics has largely substituted for social analysis of the changing meaning and experience of old age. As a result, the extent to which we have created a dependent status in old age has been obscured. This is not to say that people do not grow old and suffer from disabilities, but rather, what we regard as old age is of our own manufacture and not a function of demography or the biological ageing process (for a full account see Walker, 1980, 1981, 1983; Townsend, 1981).

The practical implication of this sort of structural analaysis is that since age and dependency are social institutions, they can be altered, as they have been in the past, through social and economic policies such as those affecting the age of retirement. In the health and personal social services there is a wide range of powerful groups and interests that may have unwittingly encouraged the myth that old age and dependency are synonymous. Staff of domiciliary services and residential homes alike, health and social services unions, social services managers and directors, local politicians, the medical profession and DHSS officials and ministers have all no doubt stressed the worrying implications of the rising numbers of elderly people in their wholly honourable pursuit of better services, conditions of service or more resources for the health and personal social services (Walker, 1982, pp. 124-5). But in doing so they have helped to spread and legitimate an inaccurate picture of elderly people and the true origins of their needs. There is a continuing danger, therefore, that policy will be formulated in a climate of alarmist speculation, following the path of least resistance, rather than on the basis of a careful analysis of actual needs among the elderly. This emphasises the fundamental role of independent research in the planning of social care.

Secondly, to conceive of increases in the numbers of elderly as a threat or burden is paradoxically, as Titmuss (1963, p.56) pointed out, to undervalue the social progress British society has made, and particularly the achievements of public welfare, in putting an end to many of the causes of premature death.

Thirdly, increases in the population in need do not necessarily result in increased public resources. As Ermisch (1983, p.283) has shown expenditure on the health and personal social services has not been sensitive in the past to increases in the need for care but, instead, has been determined by what the government has decided to spend. So, it seems that whatever pressures derive from rising numbers of elderly people in the future, the crucial factors in the allocation of resources to the health and personal social services will be political. Whether or not elderly people themselves become a more concerted political force in the battle for resources, as in the USA, is an interesting matter for speculation.

Bearing in mind these cautions and Abram's (1978a, p.5) warning that 'predictions and projections based on demographic data are, of all types of social prediction, the ones most likely to go wrong', what can be said with confidence about the size and composition of the elderly population over the coming decade or so? Continuing growth in the numbers over 65 can be expected until the early 1990s, when a slight fall will be followed by a steep rise in the first part of next century. Between 1983 and 1991 the population aged 65 and over is expected to rise by 7 per cent to 8.8 million. This follows a growth in this age group of 360 per cent since the beginning of the century. Britain shares this expansion in the population of elderly people with its EEC partners and, with the exception of Ireland, has a similar proportion of its population aged 65 and over: the proportion of the population of EEC countries in this age group varies from 13.2 per cent in Greece to 15.1 per cent in West Germany, with the UK figure at 15.0 per cent (Eurostat, 1984, pp.76-77). However, it is the projected increase in the number of elderly people aged 75 and over and especially those aged 85 or more that has been the chief focus of attention in recent years (Ermisch, 1983, p.282). The numbers aged 75 and over are expected to rise by 14 per cent by 1991 and 21 per cent by 2001, those aged 85 and over by 22 per cent and 69 per cent respectively.

The major factor of importance to social policy-makers in the ageing of the population and particularly increasing longevity is rising incidence of disability in successively older age groups (Townsend, 1979, p.706). Although there are no up to date official estimates of the full extent of disability in old age - a major deficiency that should be rectified by the OPCS survey currently underway - some indication of variations in incapacity between different groups of elderly people can be given. For example, the proportion of elderly people who are unable to go out of doors and walk down the road unaided increases by ten fold between the 65 to 69 and the 85 and over age groups. The proportion of those aged 85 and over who are unable to bath, shower or wash all over alone is seven times higher than that for those aged 65 to 69 (OPCS, 1981).

As well as indicating the existence of a significant proportion of elderly people who suffer from restricted mobility or who are unable to perform certain self-care tasks - 12 per cent of all elderly people or 990,000 people are unable to go out of doors unaided and 7 per cent, 577,000 are housebound - these statistics show that the vast majority are not troubled by illness or disability which restricts their activity to any significant extent. The most recent survey of elderly people living in the community (Hunt, 1978, p.73) also found that the majority were not functionally impaired: only four per cent could not manage to go upstairs and eight per cent could not bath themselves. Again it is among the older age groups that the greatest need and, therefore, the main demand for social services occurs. For example, those aged 75 and over are six times more likely than those in the 65 to 74 age group to have a home help (OPCS, 1982, p.154). Even so less than one in five of the 75 and overs receive a home help service.

The distribution and composition of the elderly population also has important implications for social service planning. Regional variations in the distribution of elderly people mean that the potential demand for services is higher in some areas, particularly the south coast and inner city areas of the north and north west. Then there are important differences between age groups in the proportion living alone. There has been a substantial increase in the numbers of elderly people living alone over the last 20 years to some three in ten of the population. The higher mortality rate among men than among women means that the majority of those surviving alone to advanced old age are women and the provision of care to this group is one of the main challenges facing social service planners over the next two decades. This arises from two separate factors. Not only are a large number of elderly people, and elderly women in particular, outliving their spouses for long periods but also there are a significant number of elderly people who have either never had children or who have none surviving (Abrams, 1980). Thus household composition has an important bearing on the use of social services: those aged 75 and over living alone are nearly three times as likely as those in the same age group living with a spouse to receive a home help and five times as likely to receive meals on wheels (OPCS, 1982, p.154).

On the basis of official demographic projections, then, there is likely to be an increase in the numbers needing care over the next two decades and beyond. An, admittedly unsophisticated, estimate has been made of the increases in the need for care implied by these population changes (Henwood and Wicks, 1984, p.16). Between 1981 and 1991 the numbers of people over 65 who are unable to bath themselves might increase by 16 per cent (122,000 persons), those not independently mobile by 17 per cent (183,000) and those living alone by 9 per cent (258,000), although there would be considerable overlap between these groups. If these estimates are projected forward to 2001 the increases over 1981 would be 23 per cent, 25 per cent and 9.5 per cent respectively.

Family Care of Elderly People

The need for care on the part of elderly people is likely to go on increasing, but not at an alarming rate. However when rising levels of need are coupled with the existing shortfall in formal service provision (see below) it is reasonable to express concern about the adequacy of care for a substantial minority of elderly people in the near future. Who is likely to meet the need for care?

Despite the fact that elderly people are the largest client group in the health and personal social services, the vast bulk of care is not provided publicly but privately by the family. In turn, family care is a euphemism for care by female kin (Land, 1978; Finch and Groves, 1980; Walker, 1981a). Women carry out most of the help, assistance and support or 'tending' (Parker, 1981) that caring tasks consist of. As well as doing most of the unpaid labour women bear the main burden of guilt and worry that the other side of the caring coin, love or affection, usually entails (Graham, 1983; Ungerson, 1983). A survey of carers by the EOC (1980, p.9) found that there were three times as many women carers as men. A more recent study of elderly people using short-term residential care found that 85 per cent had female carers (Allen, 1983). A detailed study of a very small sample of families caring for severely disabled elderly relatives found that the average time spent on care activities on weekdays was 3 hours 24 minutes, of which 3 hours 11 minutes was spent by wives and 13 minutes by husbands (Nissel and Bonnerjea, 1982, p.21).

The burden of care on women appears to be increasing. In a survey of women's employment, Hunt (1968, p.109) found five per cent of women aged 16-64 were responsible for the care of at least one elderly or infirm person in their household and six per cent were responsible for at least one person outside of the household. In the recent OPCS survey of women's employment, 13 per cent were found to have caring responsibilities for sick and elderly dependents. This sort of finding and the absence of any national data on carers points to the need for large scale research into the factors which encourage or inhibit the provision of care in the family.

Thus the future supply of care for elderly people is primarily a question of how far women will be prepared to continue shouldering the main responsibility for providing care.

Certainly there are powerful normative, ideological and material pressures on women, and especially daughters, to care for elderly relatives. Preliminary results from a pioneering piece of research in this country, which has examined the caring relationship from the perspective of both elderly people and their principal carers, have confirmed the continuing strength of the normative structure underlying the hypothetical decision-making process about which relatives from an available pool will provide care (Qureshi and Walker, 1985). It is possible to predict, with a high degree of accuracy, the outcome of decisions about which relatives will care, even within large close-knit kinship structures. One of the most potent influences on the 'selection' of carers is that female relatives are preferred to male relatives. The majority of carers themselves believe that they are the right person to provide care and that care for elderly people is women's work. At the same time the preference for relatives as against non-relatives by both elderly people and their relatives may set limits on the involvement of friends, neighbours and volunteers in the care of elderly people, a point I return to below.

The Supply of Informal Carers

Against the demonstrably powerful influence of norms concerning the distribution of caring functions there are several factors which might have an increasing bearing on the availability of family carers, resulting in a widening care gap, which must be considered in planning future policies.

It has already been noted that a significant proportion of elderly people are surviving without any children or other relatives. In addition there are likely to be changes in the pool of potential family carers. The decline in fertility during the 1920s and low fertility in the 1930s mean that the generation who are now 75 have fewer children than any previous generation (Ermisch, 1983, p.283). The generation who will become the elderly of the 1990s produced slightly more children but their families were still relatively small. So the ratio of potential family carers per person aged 75 and over has declined steadily over the course of this century (Eversley, 1982). There is no evidence from the recent survey of family care in Sheffield that the size of the pool of potential family carers has a significant influence on the provision of care, the crucial elements are the sex and proximity of carers (Qureshi and Walker, 1985). Although it must be pointed out that Sheffield is an area of traditionally low migration and geographical mobility might increase the importance of the size of the pool of possible carers.

Increasing longevity has made the aged carer a more common phenomenon. Again precise information is not available, but we do know that some 49 per cent of all elderly people and 35 per cent of those aged 85 or over live with other elderly people in different types of household (Hunt, 1978, p.16). In one local study it was found that 30 per cent of elderly people were receiving help from others of their generation (Green, Creese and Kanfet, 1979). While the existence of elderly carers is not a cause for concern, it is likely that in advanced old age carers will be less able than younger people to stand up to the strains of caring.

Family breakdown too is likely to have a small impact on the future availability of carers. It is not possible to predict the consequences of divorce and family reconstruction on the supply of family care and Parker's (1981, p.21) question about who will look after the dependent step-grandmothers and grandfathers of the next century remains an open one. On the basis of the differences in obligations towards the care of elderly relatives felt by daughters-in-law compared with daughters it is likely that increases in divorce will weaken the impact of the normative pressure to care. It is estimated that 5.1 per cent of women and 2.9 per cent of men aged 65 or more will have experienced divorce in 1999.

Economic changes may affect the supply of care if not the numbers available to provide care by restricting the ability and propensity of family members to help elderly relatives. It is sometimes suggested that the growth of unemployment might have a beneficial spin-off in freeing more men to take a greater share of caring tasks. On the face of it this is an appealing argument entailing benefits for elderly people. female carers and unemployed men. But it contradicts all that we know about the debilitating, isolating and psychologically damaging effects of unemployment (see for example, Hakim, 1982). What little evidence there is suggests that unemployed men are less likely than those in work to provide care to elderly relatives or to support the caring activities of their wives (Qureshi and Walker, 1985). While this points to a pessimistic view of unemployed people as a potential resource for the care of the elderly, there is one group among the newly economically insecure that does not suffer quite the same high level of stigma, loss of status and poverty as the unemployed: the early retired. Large numbers of men, predominantly in their fifties and early sixties, are leaving the labour market and might be encouraged to take part in caring activities. It is probable too that the continuing growth of family poverty with all its attendant anxieties will not contribute to the willingness of family members to care for elderly relatives. There is very little information on the relationship between economic status, income levels and the supply of informal care, a deficiency that might be felt acutely by policy-makers in the near future. The evolving relationship between the labour market, especially the growth of part-time work, and informal care is another important focus for research.

It is sometimes suggested that the increased involvement of married women in the labour market - in 1983 over half of married women aged 25 to 35 and two thirds of those aged 35 to 54 were economically active - will reduce their commitment to care. There is no evidence that this is the case. On the contrary, what is remarkable is the extraordinary lengths that many married women go to - often sustaining three separate roles at great physical cost to themselves - in order to care for elderly relatives and keep them in the community (Nissel and Bonnerjea, 1982; Allen , 1983; EOC, 1980).

This brings me to what is perhaps the greatest long-term challenge to the structure of norms and values on which the present pattern of care is based: the growing opposition on the part of women to sex-based inequality and the questions it raises about the unequal division of domestic labour, including the provision of formal care. Some feminists are directly confronting questions concerning the justice and fairness of sexist forms of care and the possibility of alternative approaches which do not exploit the low status of women (Finch and Groves, 1983; Finch, 1984), questions which will emerge in a very different form in many families caring for elderly relatives in the future. Although opposition to sex-based inequalities is unlikely, under its own steam, to have a major impact on the provision of informal care in the medium term, planning for the longer term is essential if we are to respond to the effects of changes in the roles of women which may challenge their normative designation as carers.

While the effects of these developments are uncertain, even in the long-term, the feminist critique of care does emphasise the important question: should women be the primary source of care? Policy-makers might prefer to approach this question from a different angle: what are the implications of a continuation of the present unequal sexual division in informal care? Caring entails a number of costs - financial, social, psychological and physical (Nissel and Bonnerjea, 1982; Allen, 1983) - which are not only unfairly borne predominantly by women, but because of this, they are forced to give up caring prematurely. For example, Isaacs and his colleagues (1972) found: 'The factors which made the burden of caring for an ill, old person overwhelming were, above all, the personality of the patient, the distortion of personality and behaviour caused by mental illness, and to a lesser extent the physical burden of providing night-and-day nursing care for the helpless'. If carers do give up full-time care it is because they are no longer able to bear the huge emotional and psychological costs or because they have been worn out by the sheer physical costs in terms of sleepless nights, illness and exhaustion from lifting and taking care of their relatives. It must be a matter for concern to policy-makers not only that the breakdown in informal care results in the demand for formal services but also that individual carers should be driven to breaking point before these services are made available on a casualty basis.

What is the potential of the informal sector to meet the rising needs of elderly people for care? A simple answer would be misleading because it depends on the quality of care and caring regarded as desirable for elderly people and their relatives. On the one hand there is no doubt that, in the shortterm at least, female kin will continue to meet the needs of their elderly relatives entremely effectively until they are no longer able to do so. In the medium and longterm the pressures I have outlined above will come to have an increasing influence on the provision of care. Thus to the roughly one in three of over 75s who have no children there will be added an unknown number with children or other relatives who for whatever reason cannot or will not provide care. If, on the other hand, we are seeking to promote and support informal caring networks which do not exploit the duty felt by families, and above all by women, to provide care and which does not impose enormous financial, physical, social or psychological costs on carers, then we must look to the formal sector for policies which contribute to this development. In practice this means that more resources will have to be put into helping and supporting informal care and, as the DHSS (1981, p.55) study of community care recognised, a greater recognition of the existing burden on informal carers. The Social Work Service Development Group project on support for informal carers is a step in the right direction (SWSDG, 1983) but shifts in resources are required to put policy into practice. The point has been made most recently by the authors of a study of carers of confused elderly people in the community:

> 'Something can be done to alleviate most of the problems these supporters face but it will not be done if resources are not earmarked for this purpose. Care by the family in the community does not do away with the need for services: rather it can be promoted by them' (Levin, Sinclair and Corbach, 1983).

This study also demonstrated the importance of the health and personal social services in preventing the build up of physical and emotional strain and thereby increasing the capacity of those supporting even the most difficult elderly people to care for them informally.

There is no evidence of large unused human resources in the current system of family care (DHSS, 1981, p.54). Those regarded by both elderly people and carers as the most appropriate persons to provide help are for the most part doing so and often working at full stretch. Of course there are instances of friction within families where, for example, one daughter is providing a great deal of assistance and another is not, and one of the more sensitive tasks for social scientists is to investigate not only why some people provide care but also why others do not. The only substantial untapped resource within the family is that of male kin, particularly sons and sons-in-law. Policy-makers might turn their attention to ways of increasing the willingness of men to share caring tasks. This is not a matter for the family to resolve privately because of the enormous costs that continue to fall on women and the costs that might fall on society if there were a breakdown in care. There is a need, then, for preventive action which would have the beneficial effect of promoting sex equality and reducing the need for formal services. Moreover, when we consider the financial benefits to the state of the unpaid labour of families (Moroney, 1976; and below) the case for material support for the caring activities of the family is very strong - perhaps taking the form of a social security benefit or tax concessions for those who take part-time work in order to provide care.

There is a danger, to be guarded against, of constructing policy on the basis of an over-idealised view of family life and family care. Just because the family provides the bulk of care to elderly people it is not always the best and most effective source of care (Qureshi and Walker, 1985). The provision and receipt of family care can be a difficult and mutually painful experience for both carers and elderly people. Moreover the standard of care provided in such circumstances is likely to be very poor.

Measures to improve the quality of life of carers and draw into caring those on the sidelines would not increase the supply of informal care to those elderly people who do not have close kin, or none living nearby. Here the role of neighbours, friends and volunteers assumes greater significance.

A great deal of interest has been focussed on the activities and potential role of neighbours and volunteers in care. While this is undoubtedly an important resource for care, its potential as a substitute for family or formal care is doubtful. The pioneering work of Abrams (1978,1981) on neighbouring has questioned the existence of spontaneous neighbourly care based on locality. Paradoxically it requires formal organisation to promote and sustain it. In some small close-knit communities the contribution of friends and neighbours to care can be significant (Seyd, Simons, Tennant and Bayley, 1984; Wenger, 1982) but even in this setting it is secondary to the contribution of the family (Seyd, et.al, 1984, p.33). Other research in more typical locations confirms that neighbours and friends rarely fulfil a principal carer role for disabled elderly people needing considerable daily support (Charlesworth, Wilkin and Durie, 1983, p.60; Qureshi and Walker, 1985). The future contribution of neighbours to the care of elderly people is likely to be confined to the secondary, but nonetheless important, role of supporting family carers rather than substituting for them.

For similar reasons - the need for secure, reliable and durable assistance - the potential of volunteers also needs cautious consideration. There have been a number of important experiments in collaboration between formal and voluntary services which give cause for some optimism about their wider use in a supportive capacity (Johnson and Challis, 1983, p.111). Working in conjunction with statutory services, volunteers can make a modest contribution to filling the gap in the care of the elderly (Power and Kelly, 1981). Again the use of volunteers cannot be seen as a substitute for formal services; the latter are required in order to make the most of voluntary help:

> 'In only a few situations is the voluntary sector an alternative to the statutory sector, in being able to offer a choice of services in the sense of being able to do the work now done by statutory services. Thus voluntary organisations are not a challenge to the state. They are not a challenge or able to supplant it, or carry on in parallel to it' (Hatch, 1980).

In sum, the successful provision of care by the family to the vast majority of elderly people who need it should not be taken as a cause for complacency. There is no sign of the family being less willing to care, though it may become less able to care. There is no general crisis of care on the horizon, though individual carers will increasingly experience personal and family crises. But there are factors which are likely to limit the supply of potential carers and, perhaps, inhibit the willingness of family members to care. These are likely to result in a widening of the care gap over the next two decades. This brings us to the crucial role of the formal services in filling that gap and in supporting the caring activities of families.

Community Care

'Community care' of elderly people has been a stated goal of governments of both political parties since the Second World War. But the precise meaning of the concept has varied considerably in practice and has recently been the focus of critical attention (Abrams, 1978; Walker, 1981a, 1982a). Indeed the history of community care policy provides a powerful lesson for policy-makers and planners of the dangers, to paraphrase Titmuss, of employing idealistic terms to describe aspects of public policy (for a full account see Walker, 1982a). The most recent emphasis of policy rhetoric has swung firmly behind care by the community: 'care in the community must increasingly mean care by the community' (DHSS, 1981a, p.3). As we have seen, the community or the family is already providing most of the care and there are limitations on the ability of informal carers outside of the family to deliver the same level or intensity of care as the family or the formal sector. Is there scope in the formal sector to fill the growing care gap?

Again the answer depends on the aims and priorities underlying policy. If our overriding concern is with a narrow form of economic efficiency in the public sector - the provision of services at the least cost to the Exchequer - then the answer will be straightforward: privatise the care of elderly people in the formal sector, providing the subsidy to the private sector is less than the cost to the public sector. If there is strong ideological opposition to the public sector then the final caveat might also be dispensed with (Minford, 1984). But the hallmark of public provision and one of the key differences between the public and private sectors, is concern with social efficiency as well as economic efficiency (Hirsch, 1977; Walker, 1984), though it may reasonably be argued that this dual concern has not been translated successfully into practice. This means that policy-makers in the public sector are interested in the impact of policy or policy effectiveness as well as in cost efficiency (DHSS, 1981, p.16). Assuming that this balanced approach continues to influence policy development then critical questions must be asked about efficiency and effectiveness in both public and private sectors. There has been a rapid growth in recent years in studies of relative cost efficiency between the two sectors, but as the DHSS study of community care recognised, research on the effectiveness of provision, particularly (I would add) from the clients' perspective, is less developed (DHSS, 1981, p.16).

The current emphasis on care by the community stems primarily from a desire to limit the cost of care to the public sector. Total anticipated expenditure for all age groups on the personal social services in 1984/5 is £2,260 million, with about half going to services for the over 75s. Health service expenditure in this group is higher, at approximately £3.6 billion, and the transfer of resources from 'treatment' to care offers one of the best hopes of improving the quality and scope of caring services while remaining within or close to existing resource allocation. In the personal social services too, over half of expenditure is taken up by residential services, with only one-fifth going to community care. So the longstanding policy of shifting resources from residential to community services has not made much impression on the actual distribution of expenditure on these services.

In order to put it in context, public expenditure on the care of elderly people might be compared with estimates of the hypothetical financial contribution made by family carers. Assuming a relatively low rate of pay and small number of hours worked Henwood and Wicks (1984, p.12) put the annual 'cost' of such care at between £3.7 and £5.3 billion (depending on the number of hours worked).

Restrictions on expenditure are worrying not only because increasing numbers of frail elderly people will face a growing care gap in the informal sector but also because, as the table opposite shows, there is already a substantial shortfall of services or a public care gap because expenditure has failed to keep pace with need.

Home help provision nationally averages only half of the, (now defunct), guideline figure of 12 home helps per 1000 population (DHSS, 1977). There is evidence too that increases in the number of clients helped have been at the expense of a reduction in the average hours per client, and that only just over half of elderly people classed as being in severe, considerable or moderate need actually received a home help (Bebbington, 1981). Expenditure cuts have contributed to this shortfall and, as the DHSS (1981, p.67) study of community care recognised, this has inhibited the development of community care as a replacement for residential care:

> 'In the personal social services, some elements of the package of care which might be provided as an alternative to long-term hospital care do seem to have been held back as a result of expenditure constraint. The growth in the number of home helps for example, had not kept pace with the increasing number of elderly people'.

Insufficient weight appears to have been given to the impact of demographic changes on the health and personal social services. An allowance of 2 per cent per annum is made in planning public expenditure to meet demographic and other pressures in the personal social services. This does not match the increases in population shown in the table and the figure has been criticised as being, at best, 'a well-informed guess' (Webb and Wistow, 1982). Furthermore there is considerable variation between local authorities in the extent to which even this level of growth has been maintained.

The substantial shortfall in community care services in the face of rising need represents a powerful argument for increased resources for the personal social services in the annual public expenditure round. But are there possibilities for freeing resources to meet the needs of elderly people more effectively from within the existing allocation to the health and personal social services? There would appear to be three main ones: a dimunition in hospital and residential care, increasing cost effectiveness and privatisation. Each will be considered briefly.

Elderly Population and the PSS: Indices of Change 1975/6 to 1981/2

	1975/6	1975/6	1976/7	1977/8	1978/9	1979/80	1980/1	1981/2	% change 81/2 on 75/6
Total elderly population (000's)									
aged 65+	6,811.2	100	102.8	102.8	104.6	105.3	107.6	108	+8
aged 75+	2,446.3	100	103.3	103.3	107.2	109.0	113.0	115	+15
Total elderly in residential care 000s	120.3	100	104.0	105.5	104.8	104.1	101.6	105	+5
Per thousand population 65+	17.7	100	101.1	102.9	100.0	98.9	94.4	97	-3
Per thousand population 75+	49.2	100	101.0	102.0	97.8	95.5	89.8	87.3	-12.7
Home helps (whole time equivalents) 000s	50.1	100	93.0	97.2	99.2	96.9	100.2	102	+2
Per thousand population 65+	7.4	100	90.5	94.6	94.6	91.2	93.2	94.6	-5.4
Per thousand population 75+	20.5	100	89.8	94.2	92.7	88.8	88.8	88.3	-11.7
Meals 000s	41,276	100	100.2	99.1	97.5	103.9	99.9	99.4	-0.6
Per thousand population 65+	6,060	100	99.9	96.8	93.1	98.1	92.9	92.2	-7.8
Per thousand population 75+	16,872.8	100	99.4	96.2	91.0	98.4	88.4	86.5	-13.5

Source: Henwood and Wicks, 1984, p.14

Although the current interest in community care derives primarily from financial considerations, it coincides with a long-standing critique of the detrimental impact of residential care on elderly people. Ever since the pioneering work of Townsend (1962) there has been a long series of research studies confirming his findings that significant proportions of residents of old peoples' homes are physically and mentally capable of living more independently in the community, and that for a large number of people admission to a home rests on social factors such as the lack of alternative forms of care, rather than physical or mental disability (for a summary of research see Townsend, 1981). There is some indication too that, once people have been admitted, residential homes can increase their dependency (Walker, 1982) but further research is required on this important issue. Coupled with criticisms of residential care is the continuing finding of research that elderly people and their families are extremely reluctant to contemplate admission to a home (Qureshi and Walker, 1985).

There is evidence that the need for residential care can be delayed by innovative schemes like the Kent Community Care Project. But there are few examples of attempts to replace residential care with an intensive community-based package. Where this has been attempted there are doubts whether it would prove a cheaper option in the long run (DHSS, 1981, p.30). As usual this depends on the way in which costs are calculated and further research is required on cost comparisons. One important focus for this sort of research will be the Elderly Person Support Unit's innovation in Sheffield. Sheffield Family and Community Services Department is replacing the traditionally divided structure of services for elderly people - into domiciliary, day care and residential care - with an integrated and flexible form of provision which includes a new sort of all-purpose community support worker. An evaluative project has been funded by the Joseph Rowntree Memorial Trust (Qureshi and Walker, 1983).

The development of a concerted community care policy to replace traditional long-term residential care would require careful planning and preparation. It would be intended to foster independence and inter-dependence rather than dependence. It would require the cooperation of health and housing authorities. It would however meet with powerful opposition from those that have a strong interest in residential provision. Even if it proved feasible it might not be cheaper than residential care; however it might meet the needs of elderly people more effectively. These are issues for further research.

Similar questions might be asked about long-term hospital care for elderly people and the possibilities for its replacement with community care and community nursing (the EPSU innovation includes provision for community nursing) and the further development of segregated, sheltered and very sheltered housing provision. But in each case issues of cost-effectiveness must be equated with the effectiveness of care in meeting the needs of elderly people.

The potential for developing alternatives to residential care and treatment has yet to be explored fully. But whatever initiatives are attempted locally, they are unlikely to be successful without a firm foundation of community care services (Webb and Wistow, 1983).

Secondly, there is likely to be considerable scope for improving cost-effectiveness in the health and personal social services in order to free resources for community care. A recent study of social services to the elderly, by the Audit Commission (1983), suggests that savings might be made, for example, by improving the priority allocation of hospital beds, replacing residential care for some with community-based services, improving the operation of the home help and meals services and improving the coordination between residential and domiciliary care. Although these recommendations cannot necessarily be put into practice quickly and easily, they do suggest that it is possible to improve the cost-efficiency of the public sector and thereby, perhaps, provide resources to help fill the care gap. The study concluded that authorities should seek more information about the clients of services in order to support effective allocation to individuals (Audit Commission, 1983, p. 20).

Thirdly, there is privatisation, an issue which could take up a seminar on its own. As I have already indicated, a simple way of freeing health and personal social service resources would be to privatise care. Indeed this seems to have been proceeding quietly in the residential sector over the last few years. There has been a substantial increase in private residential accommodation in response to the inability of local authorities to keep pace with need and the active promotion by the government of the private sector - private and voluntary homes now represent about one-half of all registered places (Johnson, 1983).

This growth has not taken place on the basis of careful policy formation and evaluation. Quite apart from the fundamental differences between public and private services in motivation and accountability and the implications of a residual public sector for the poorest, there is very little information on the comparative effectiveness and quality of care in the two sectors on which to plan the development of policy. There is some evidence that private care operates at lower cost than public are, primarily due to the lower levels of wages in the former (Judge, Knapp and Smith, 1983) but there are no measures of the outcomes of different forms of care. In the absence of more detailed research it would be difficult to recommend a policy of privatisation in order to provide resources for community care. While we wait for this information, the public sector has important lessons to learn from the private residential sector, such as the effectiveness of smaller units and flexible regimes. It must be pointed out, equally, that although privatisation of residential care would shift some costs to the private sector it would contradict the current policy of care in the community. Moreover there is no evidence that rapid growth of the private sector in recent years has resulted in the allocation of any extra resources for the public sector.

What scope is there for the possible further spread of privatism in the public sector in the form of charges for services, which contributed £306 million to the personal social services in 1981/2? Leaving aside obvious universalistic objections, there is little possibility of increasing revenue from charges for the care of the elderly without considerable social costs because of the widespread poverty among this group (Walker, 1980, 1981) and their detrimental impact on the take-up of services among those most in need (Judge and Matthews, 1980, p.120). Research on the impact of charges on those receiving a home help also suggests that they operate to reduce the living standards of some of the poorest elderly people (Foster, 1983, p.155).

Conclusion

This review of some aspects of the social care for elderly people shows that there will be a growing need for care within both the informal and formal sectors over the next 10-20 years, on top of the existing shortfall in the provision of domiciliary services. There will be some scope for increasing the supply of human resources for care, in the form of male kin and volunteers, but to achieve this requires promotional policies and formal organisation. The 'Helping the Community to Care' initiative is indicative of the sort of programme required, but it is very modest. There is scope too for financial savings resulting from greater efficiency in the delivery of care. But even if these extra resources are secured, an increasing public expenditure commitment to domiciliary services is necessary if the promise of community care is to become a reality.

What should be the aim of policy over the next 10 years? The central requirement is for policies which share care more effectively with the family and more equally within the family. This means moving from a casualty service, which substitutes for the family following breakdown, to ~~a~~ more supportive and preventive role. Failure to adopt this position in the past may be explained by the twin fears about the resource implications and the supposed threat that state interference might discourage the family from caring. There is no evidence whatsoever that the existence of public services has made the family less willing to care and it is hoped that research has dispelled the fears of policy-makers on this score (Moroney, 1976, p.125). In fact recent research shows that formal services can actively encourage and support the provision of care by the family. It may well be that shared care will be more expensive, but against this must be weighed the benefits of an improved quality of life for elderly people and their carers and the relatively small total cost involved.

Because in so many aspects of social care we are entering uncharted waters, a partnership between research and policy-making is essential. Some suggestions for research have been made already. There are likely to be three priorities in the medium term: a large scale study of family care, focussing primarily on the dynamics of reciprocity within the family and variations in caring arrangements; evaluation of formal care delivery in the public and private sectors, especially client preferences, the outcomes of care and the relationship between service delivery and dependency; and continual monitoring and evaluation of promising innovations in social care, particularly alternatives to residential and hospital care. This sort of research programme would ensure that policy-makers have a sound basis on which to develop policies to provide care efficiently and effectively to elderly people.

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